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Evaluation of Implementation Process: Community Long Term Care System (CLTCS) in South Carolina

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EVALUATION OF IMPLEMENTATION PROCESS: COMMUNITY LONG TERM CARE SYSTEM (CLTCS) IN SOUTH CAROLINA

by

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EVALUATION OF IMPLEMENTATION PROCESS: COMMUNITY LONG TERM CARE SYSTEM (CLTC) IN SOUTH CAROLINA

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ABSTRACT

There is a growing awareness that institutional health care costs are rising at a rapid rate. A sound community support system can provide adequate care to the aged and the disabled as well as reducing the costs of institutional care. A viable community support system requires the coordination of health care professionals in all agencies in the community, as well as support from clients and their families. South Carolina is currently implementing a new form of community support system called Community Long Term Care System (CLTCS). This system is expected to achieve coordination of services for all clients through service management thus providing a viable alternative to institutional care. The paper will analyze the implementation process of this agency, focusing on the Greenville regional CLTC, and examine some of the attitudes of community long term care agencies in Pickens County towards CLTC. The purpose is to identify some of the political, economic and community disapproval and/or support existing among local agencies. Communication with the public is very important to the success of the implementation process.

CHAPTER I - PURPOSE, SCOPE AND PLAN OF THE PAPER

INTRODUCTION

Planners in the health care profession are increasingly concerned with the rising costs of institutional health care especially for the aged and the disabled. Between 1970 and 1978, the population of elderly in South Carolina increased by more than 30 percent. Based on national estimates of disability rates, there were approximately 20,000 elderly disabled in South Carolina. The nursing home industry is a major provider of institutional care due to governmental policies that promote institutional care. Medical costs for such care have increased rapidly; in South Carolina costs have risen from $68.4 million in 1978 to $99.3 million in 1980.

In the past decade, community support system (CSS) has improved the limitations of institutional long term care for this particular group of individuals. CSS is defined as " a comprehensive network of services in a community designed to help older persons maintain that set of living arrangements which they desire and which seem most appropriate for their circumstances as defined by the older persons themselves, their families and health practitioners." CSS has proven to be economically feasible as well as psychologically enhancing to both aged and disabled clients and their families. More important, it's arrangement is much more flexible and catered to clients' needs than institutional care. It is the responsibility of health care planners to explore fully the opportunities CSS can provide as an answer to lowering institutional costs.

The purpose of this paper is to examine a new form of community support system in South Carolina. It is known as Community Long Term Care System (CLTCS). This system was established by South Carolina General Assembly in 1978. It involves several governmental agencies such as

Department of Social Services, Health and Environmental Control, Mental Retardation, Mental Health, and Council on Aging. The role of such agencies is to aid CLTC in coordinating existing services in the community to help a Medicaid-eligible aged or disabled person to remain at home as long as possible. They believe that community support system is a viable alternative to institutional care and an answer to lowering institutional costs.

In 1979 CLTC first launched an experimental project in Spartanburg County. The project demonstrated that a policy of mandatory pre-nursing home admission assessment and service management by experienced professionals was effective in helping disabled Medicaid clients obtain new as well as existing community services for in-home care. Cost comparisons between experimental and control groups gave some indication that the CLTC program had an impact on nursing home use and Medicaid costs. However, definitive statements are not possible until 1984 when the project is completed and results analyzed.

A statewide implementation of the program is now underway. It was originally intended that there would be ten regional offices that cover the entire state. Owing to budget constraints, however, Greenville region is one of four operating since March 1983. Greenville CLTC serves Greenville, Anderson, Oconee and Pickens counties. The other six regional offices will open later in 1983.

This paper will examine the initial implementation phase of Greenville CLTC, with an emphasis on Pickens County in particular. Some of the major questions studied include the goals and objectives of Greenville CLTC, its operating phase and condition, its coordinating ability and relationship

with the state, and the local attitudes of agencies in one of the counties.

Health care planners are not only concerned with the formation of CLTC as a new source of community support system, they are also interested in examining its implementation to determine if they achieve the goals of satisfying the needs of community as well as lowering costs of health care. However, it would be impossible at this stage to come up with specific successes or limitations of the program due to its recent operation. Nevertheless, a proper direction in implementation is helpful for almost any program.

SCOPE AND PLAN OF THE PAPER

The second chapter of the paper gives an overview of long term care services in the United States. It includes the definition and measurement of functional disability, the users of long term care services, current nursing home utilization and projections for the future. It also discusses briefly the current problems of long term care system: increase in public and private costs, inadequate accessibility to services by clients, and poor quality of services. The community support system (CSS) is seen as a viable alternative to insitutitional care. The individuals and organizations involved in CSS are clients and their families, taxpayers, political office holders, community service agencies such as homemaker services, and institutional long term care services such as nursing homes. The individuals and organizations within the CSS are interwoven in a social setting in which coordinated role playing is very essential.

Chapter III is a case study of CLTC program: the experimental project in Spartanburg County. There is a description of its goals and objectives,

its project operations, the types of services (existing as well as newly created) it provides, the characteristics of project clients, and finally an examination of its progress: service utilization and costs, and basis for research and development.

Chapter IV is a study of the statewide implementation phase in Greenville region. A literature review on criteria for successful implementation is stated. There are four factors that can contribute to a successful implementation of any program. These four factors are: effective communication, adequate resources, supportive disposition of implementers, and an appropriate bureaucratic structure. In conjunction with the four factors for success, there are also five reasons for policy failure: vague or unrealistic goals, lack of adequate support, poor implementation procedures, complexities of intergovernmental actions, and economic environmental forces. The Greenville office will be evaluated on the basis of such criteria for success/failure of the implementation process.

The last part of Chapter IV is a brief discussion of how Pickens County local DSS and CoA offices view the Greenville regional office. There are opposing points of view towards Greenville CLTC. This is an important factor that cannot be ignored, since it concerns one of the factors that can contribute to policy failure: lack of adequate community support.

Chapter V is a summary and conclusion on the findings of the study towards implementation of CLTC. The implementation process is of major concern to planners because it determines the success and failure of the outcome, and it involves three stages: policy formation, policy implementation and policy evaluation. This paper achieves the examination of the first two stages. The last stage of policy evaluation is too early

at this point to examine.

CHAPTER II - OVERVIEW OF LONG TERM CARE SERVICES IN THE UNITED STATES

INTRODUCTION

The purpose of this chapter is to give an overview of the health conditions of our elderly population and their need for long term care services. The chapter is divided into four parts:

(1) The first part describes the need for long term care services by the elderly population: the definition and measurement of functional disability, the population estimates of functional disability, the users of long term care services, current nursing home utilization, and projections for the future.

(2) The second part of the chapter describes the community support system (CSS): the definition of CSS; the individuals and organizations involved in the creation of CSS: clients and their families, taxpayers, political office holders, community service agencies such as homemaker and congregate meals services, and institutional long term care services such as nursing homes. The individuals and organizations within the CSS are interwoven in a social setting in which coordinated role playing is very essential.

(3) The third part of this chapter discusses briefly the current problems of long term care system, these include: increase in public and private costs, inadequate accessibility to services by clients, and poor quality of services.

(4) The fourth part of the chapter discusses the viability of community support system as an alternative to institutional care based on a study done by DHHS. The chapter also includes an appendix with more details on the income and health policies and programs pertaining to long term care for the elderly population.

THE NEED FOR LONG TERM CARE SERVICES

The term 'long term care' describes a range of medical and supportive services for individuals who have lost some capacity for self-care due to a chronic illness or condition and who are expected to need care for an extended period. The services involved can be provided either formally - by individuals or agencies who are paid for their services - or informally - by relatives or friends who provide assistance without pay. The need for formal services is most often influenced by the presence of a disabling chronic disease or condition.

Definition and Measurement of Functional Disability

When a person has a chronic disease or illness that causes both functional impairment and physical dependence on others, the situation is referred to as 'functional disability'. Unfortunately, there is no nationwide survey that collects data which measures the concept directly. The nationwide Health Interview Survey (HIS), conducted annually by the National Center for Health Statistics, does collect data on three related measures, specifically:

> "1.) The presence of a chronic disease or conditon;
> 2.) Limitations in mobility and/or usual activity;
> 3.) The need for assistance in basic activities of daily living (ADL) such as bathing, dressing, eating, and going to toilet."
> (pp.3, DHHS, 1981)

One thing we should bear in mind is that the presence of a chronic condition does not mean that the person needs to be in a formal setting such as a long term care facility. The presence of chronic disease is often only felt to be a primary indicator that a person is at risk of needing long term care. It is estimated that about 40 percent of the U.S. population suffers from one or more chronic ailments. For many of these

individuals, their illness can still enable them to go about their daily activities without much hindrance or need for assistance. Thus, presence of a chronic condition is too broad a measure to serve as a proxy for functional disability.

The second measure - activity limitation - is a better indicator of functional limitation than the simple presence of a chronic condition. The HIS gathers data on four levels of activity limitation. Respondents are asked if they are:

> "1.) unable to carry on the major activity of their age group (i.e. work or housework for an adult);
> 2.) able to carry on their major activity but are restricted in amount or kind of activity;
> 3.) able to carry on their major activity but are restricted in amount or kind of other activities (e.g. recreation); or
> 4.) free of any limitations or activities." (p. 4, DHEW, 1981)

The limitation to this measure is that 'major activity' varies in degree and with age. Some people may not want to admit that they cannot carry out major activities.

The third measure - the Index of Activities of Daily Living - measures the ability to perform a range of specific self-maintenance activities essential to daily living. The index is based on an evaluation of the independence or dependence of individuals with regard to six specific functions: bathing, dressing, going to the toilet, transferring, continence, and feeding. This measure has an advantage, it does not have the pressures of social roles. However, the approach may understate need because it omits 'instrumental' ADL activities such as shopping, cooking, and cleaning. People who live alone and cannot cook their meals or clean their homes will need some degree of outside assistance in order to maintain themselves.

Population Estimates of Functional Disability

Table 1 presents data on the prevalence of activity limitation due to chronic conditions. In 1977, 14 percent of the noninstitutionalized U.S. population were estimated to suffer some degree of activity limitation due to a chronic condition. Of these, about 4 percent were unable to carry out their major activity. The prevalence of activity limitation rises dramatically with age; the elderly are 4.5 times more likely to suffer activity limitation than those under 65. The association with age is even more striking when the elderly population is subdivided. The percentage of elderly who are unable to carry out their major activity increases from 14 percent among 65-74 year olds to 33 percent for those age 85 and over. (pp. 5, DHEW, 1981)

TABLE 1

PERSONS WITH ACTIVITY LIMITATIONS DUE TO CHRONIC CONDITIONS, BY AGE U.S. NONINSTUTIONAL, 1977

	AGE						
	Total	Under 25	25-44	45-64	65-74	75-84	85 and over
Total Population (in thousands)	212,153	91,249	55,280	43,357	14,259	6,652	1,354
	PERCENTAGE						
No Limitation	86.5	95.8	90.4	76.9	61.4	51.6	36.8
Limited but not in Major Activity	3.1	1.8	2.9	4.5	5.4	6.0	6.6
Limited in Kind or Amount of Major Activity	6.7	1.9	5.0	12.3	18.7	22.3	23.6
Unable to Conduct Major Activity	3.6	0.3	1.4	6.2	14.4	22.0	32.9

SOURCE: 1977 National Health Interview Survey (p. 5, DHEW, 1981)

Data on need for personal care assistance and ADL show a similar pattern, although the absolute numbers are smaller. Table 2 presents the number of noninstitutionalized persons needing assistance in bathing, dressing, eating, or going to the toilet as a percentage of the total population for each age group. Only 0.1 percent of the total population are dependent in these four ADLs. Those age 75 and older are over 20 times more likely to need personal care assistance in at least one of these four basic activities than those under age 65.

TABLE 2

PERSONS WITH ACTIVITY LIMITATION, AND PERSONS DEPENDENT IN VARIOUS ACTIVITIES OF DAILY LIVING (ADL)*, BY AGE U.S. NONINSTITUTIONAL, 1977

	Total	Under 21	21-44	45-64	65-74	75-84	85 and over
Total Population (in thousands)	212,513	76,191	70,337	43,357	14,259	6,652	1,354
With Activity Limitation	13.5	3.7	8.7	23.0	38.6	48.4	63.2
Dependent in at at least one ADL	0.7	0.1	0.3	0.7	2.2	5.8	15.0
Dependent in all four ADLs	0.1	0.05	0.04	0.08	0.4	0.6	3.7

* Includes bathing, dressing, eating, and going to the toilet.

Source: 1977 National Health Interview Survey (p . 6, DHEW, 1981)

The Users of Long Term Care Services

If need for long term care services is difficult to estimate, the need for formal services is even more so because many of them are neither medically nor technically complex. Thus, they often can be provided by untrained family or friends. Two individuals with the same functional disability but different levels of family support may require very different amounts of formal care. In examining factors associated with the need for nursing homes, several predictors such as age, sex, marital status, and availability of other family supports are used.

1. Age and Functional Disability

Age is the most obvious demographic factor associated with the need for long term care; nearly 9 out of 10 persons who reside in nursing homes are age 64 and over. Further, the percentage of elderly residing in nursing homes rises dramatically with age, from about 1.4 percent for those in the 65-74 age group to more than 20 percent for those age 85 and over. Table 3 shows the percentage of persons having ADL dependency and percentage of persons in nursing homes, by age.

TABLE 3

PERCENTAGE OF PERSONS HAVING ADL DEPENDENCY AND PERCENTAGE OF PERSONS IN NURSING HOMES, BY AGE

Age Group	(1) Percent Having ADL Dependency *	(2) Percent Residing in Nursing Homes	(3) Ratio Between (2) and (1)
45-64	1.2%	0.3%	.24
65-74	3.5%	1.4%	.4
75-84	11.3%	6.4%	.56
85 +	35.1%	21.6%	.61

* These include all persons who either reside in a nursing home or reside in the community and are dependent in one or more activities of daily living.

Source: Combined data from the 1977 National Nursing Home Survey and the 1977 National Interview Survey (p . 7, DHEW, 1981)

As indicated in the table, the percentage of people who are dependent in at least one ADL function increases ten times (from 3.5 percent to 35.1 percent) from the 65-74 age group to the 85-and-over group, while the percentage residing in nursing homes rises more than 15 percent (from 1.4 percent to 21.6 percent) for the same age groups. The third column shows the ratio of persons having an ADL dependency who reside in a nursing home; it rises from .24 for the 45-64 age group to .61 for the 85 and over age group.

Thus, as a person ages, a serious chronic condition with resulting functional limitation is more likely to lead to institutionalization. Increased functional disability alone, however, does not explain the higher nursing home utilitization rate among the very old. There are also other factors which may help to explain higher utilization rates.

2. Sex and marital status

Table 4 shows that women tend to use more nursing home care than men because they are more likely to become widowed. Also, the lack of a spouse is a critical determinant of institutionalization. The use rates for the unmarried (widowed and single) are also considerably higher than for the married. The total percentage of elderly using nursing home was 1.2 percent for the age group of 65-74; however, at age 85 and over, the percent rises to 25. The total percentage of married individuals at age 75-84 was 2 percent, while the percentage of widowed individuals for the same age group was 8 percent.

3. Other Informal Supports

Numerous studies also reveal the importance of children, other relatives, and close friends in permitting the disabled to remain in the

TABLE 4

PERCENTAGE OF ELDERLY IN NURSING HOMES AS A FUNCTION OF AGE, SEX AND MARITAL STATUS, 1973

		Total	Married	Widowed	Single
	Total	1.2	0.4	2.1	4.1
65-74	Male	1.0	0.3	1.9	5.5
	Female	1.3	0.4	3.2	3.1
	Total	5.8	2.0	7.9	10.2
75-84	Male	4.0	1.7	7.8	11.4
	Female	6.9	2.6	7.9	9.5
	Total	25.1	11.3	27.5	32.3
85 +	Male	19.0	9.2	24.3	32.1
	Female	27.9	17.0	28.4	32.3

Source: Combined data from the 1973-74 National Nursing Home Survey and the 1974 National Health Interview Survey (pp. 9, DHEW, 1981)

community. Nationwide, four out of five older people have at least one surviving adult child, but almost half (46 percent) of the institutionalized elderly are childless. Among elderly women, size of family is directly related to the proportion of widows and single women living with relatives and inversely related to the proportion living in institutions. Childless women at any age have higher rates of institutionalization than their counterparts who have children. Finally, the composition of family membership also influences the availability of social support. (pp. 10, DHEW, 1981)

Current Nursing Home Utilization

The Survey of Institutionalized Persons (SIP) conducted by the Census Bureau in 1976, provides data on the utilization of nursing homes and other long-term care institutions.

Two-thirds of the estimated 1.6 million residents in the institutions surveyed in 1976 were 65 years of age and over. Nearly 70 percent of institutionalized people 65 years of age and over were women. (pp. 424, Marquis Media, 1977)

Seventy-nine percent of institutionalized people 65 years of age and over entered institutions primarily because they needed medical or nursing care. Another 13 percent entered because their families were unable to care for them.

According to preliminary data from the National Nursing Home Survey, there were 1,287,400 residents in nursing homes in 1977. This NNHS survey includes data from all types of nursing homes, including domiciliary care homes and personal care homes without nursing. About 85 percent of nursing

home residents in 1977 were 65 years of age and over.

The services needed and received by people in institutions in 1976 varied by age. The need for medical and nursing care rose sharply with age: however, the need for educational training and social workers declined with increasing age.

Statistics also show that more than half of the residents in nursing homes in 1977 had been in another health facility prior to their admission to the nursing home, and more than half of these had been in general or short-stay hospitals. Sixty-four percent of the residents in nursing homes in 1977 had been in the home for at least a year, and 31 percent had been in for 3 years or more. However, of the patients discharged in 1976, 52 percent had been in the home for less than 3 months. Less than 10 percent of patients discharged from nursing homes in 1976 had been in the home for 3 years or more.

The disparity between the length of time spent in the facility by residents and discharged patients suggest that there are two separate groups of persons who use nursing homes - those admitted for relatively long periods of time because there is little chance for improvement in their chronic problems, and those admitted for relatively short periods of time because they need recuperative care.

Prospects for the Future

1.) Projected Growth in the Aging Population

America is an aging society. In 1900, individuals over 60 were only about 6.4 percent of the population. By 1977, it had tripled to 15 percent Table 5 shows the changing age composition of the American population: the percent age 65 and over as a proportion of total population.

Table 5: THE CHANGING AGE COMPOSITION OF THE AMERICAN POPULATION: PERCENT AGE 65+ AS A PROPORTION OF TOTAL POPULATION

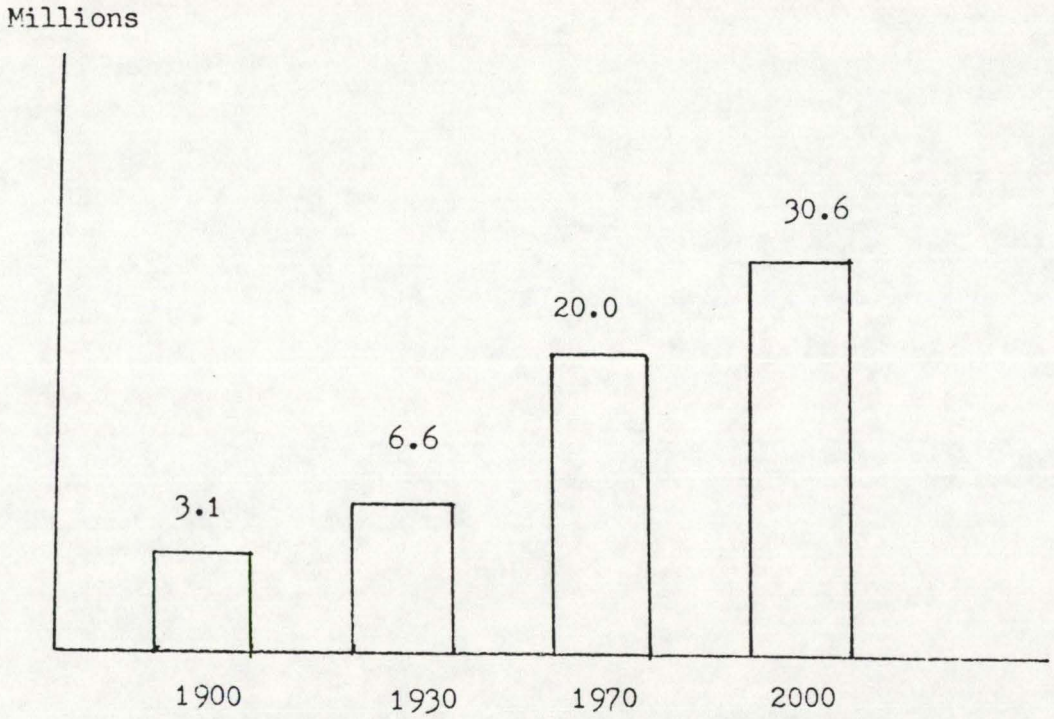
Year	% 65+
1870	3.0
1880	3.4
1890	4.2
1900	4.4
1910	4.5
1920	4.7
1930	5.6
1940	6.8
1950	8.2
1960	9.2
1970	9.8
1975	10.5

Source: Data from Census of Population, 1960 and 1970, PC(1)-(1B) and Current Population Roports. Series P-25, Nos. 519 and 601. (p. 135, Berghorn, 1981.)

By the year 2030, those who were part of the post-World War II baby boom would have become 65 years of age. Between 1980 and 2030, the total population is projected to grow by 40 percent. In contrast, the elderly population will double to a total of 55 million, or 22 percent of the population. Further, the over-75 group is growing at an even faster rate. Currently, 38 percent of the elderly are age 75 or older; by 2030, this figure will increase to 45 percent. Those age 85 and older now number about 2 million persons; by 2035 this group will triple to 6 million people. Table 6 shows the projected growth of elderly population age groups, 1980 to 2030. Table 6 shows the growth of the older population in the twentieth century.

TABLE 5

GROWTH OF THE OLDER POPULATION IN THE TWENTIETH CENTURY



Source: Facts About Older Americans, 1976, DHEW Publication No. (OHD) 77-20006.
(p . 135, Berghorn, 1981)

As indicated earlier, more women will survive over men and therefore a female biased sex ratio will exist. This 'old-old' group of individuals over 75 is characterized by more widow-hood, lower income, poorer mental and physical health, a higher degree of medical, hospital, long term institutional and non-institutional care. This level of care is also the most costly and difficult to administer. (Winston-Wilson, 1977)

There will also be a change in the dependency ratio as fertility rates drop and life expectancy increases. The ratio is simply the number of persons in the 'non-working' years (i.e., under 16 and over 64) per 100 persons of working age (16-64). Table 7 shows life expectancy at birth, males and females from 1960 to 1977.

LIFE EXPECTANCY AT BIRTHS, MALES AND FEMALES, U.S. POPULATION, 1960 TO 1977.

Year	1960	1965	1970	1973	1974	1977
Males	66.6	66.8	67.1	67.6	68.2	72.0
Females	73.1	73.7	74.8	75.3	75.9	81.0

Source: Statistical Abstracts of the United States, January 1978, Bureau of Census (p. 140, Berghorn, 1981).

The ratio of retirees to the working population has enormous implications since the costs must be borne by a smaller work force. According to the Social Security Administration (Miami Herald, 1976), there are 30 people drawing Social Security in 1976 for every 100 active workers. By 2030, the ratio would be 45 to 100. In 1980, the dependency ratio stands at 55, which means that for every two persons who work, one is supporting another person in Social Security. If the retirement age is not raised, and if fertility remains relatively low, the ratio will begin rising in about 20 years and will reach 67 by 2030, a 22 percent increase over 1980. (DHEW, 1981) Table 8 shows median income of families with heads 65 years old and over, by type of family and race of head, from 1950 to 1974.

Table 8 :

~~Table 6-6~~. MEDIAN INCOME OF FAMILIES WITH HEADS 65 YEARS OLD AND OVER, BY TYPE OF FAMILY AND RACE OF HEAD, AND OF UNRELATED INDIVIDUALS 65 YEARS OLD AND OVER, BY RACE AND SEX: 1950 TO 1974

(Persons as of March 1975, March 1971, March 1968, March 1966, March 1961, and March 1951)

Race and year	Families					Unrelated individuals		
	Total	Male head			Female head	Total	Male	Female
		Total	Married, wife present	Other marital status				
HEAD 65 YEARS OLD AND OVER								
All Races								
1974	$7,298	$7,234	$7,177	$9,281	$7,723	$2,956	$3,405	$2,869
1970	5,053	5,011	4,966	6,722	5,370	1,951	2,250	1,888
1967[1]	3,908	3,845	3,817	4,485	4,408	1,477	1,804	1,409
1965[1]	3,514	(NA)	(NA)	(NA)	(NA)	1,378	(NA)	(NA)
1960	2,897	2,857	2,814	4,053	3,139	1,053	1,313	960
1950	1,903	(NA)	(NA)	(NA)	(NA)	646	(NA)	(NA)
White								
1974	7,519	7,387	7,315	10,603	8,525	3,073	3,730	2,959
1970	5,263	5,177	5,107	7,320	5,909	2,005	2,365	1,937
1967[1]	4,043	3,949	3,907	4,955	4,756	1,511	1,897	1,437
Black								
1974	4,909	5,066	5,075	5,045	4,602	2,152	2,385	1,998
1970	3,282	3,393	3,359	(B)	2,878	1,443	1,708	1,357
1967[1]	2,609	2,551	2,556	(B)	2,808	1,127	1,299	1,058
ALL FAMILIES OR UNRELATED INDIVIDUALS								
All Races								
1974	12,836	13,788	13,847	11,737	6,413	4,439	5,998	3,493
1970	9,867	10,480	10,516	9,012	5,093	3,137	4,540	2,483
1967[1]	7,933	8,358	8,398	6,804	4,269	2,379	3,514	1,917
1965[1]	6,957	7,310	7,330	6,515	3,535	2,153	3,194	1,767
1960	5,620	5,857	5,873	4,860	2,968	1,720	2,480	1,377
1950	3,319	3,435	3,446	3,115	1,922	1,045	1,539	846
White								
1974	13,356	14,055	14,099	12,438	7,363	4,636	6,357	3,723
1970	10,236	10,697	10,723	9,524	5,754	3,283	4,864	2,615
1967[1]	8,234	8,557	8,588	7,353	4,855	2,470	3,881	1,998
Black								
1974	7,408	10,365	10,530	7,942	4,465	3,059	4,627	2,343
1970	6,279	7,766	7,816	6,751	3,576	2,117	3,320	1,651
1967[1]	4,875	5,737	5,808	4,478	3,004	1,760	2,756	1,358
RATIO, HEAD 65 YEARS OLD AND OVER TO ALL FAMILIES OR UNRELATED INDIVIDUALS								
All Races								
1974	0.569	0.525	0.518	0.791	1.204	0.666	0.568	0.821
1970	0.512	0.478	0.472	0.746	1.054	0.622	0.496	0.760
1967[1]	0.493	0.460	0.455	0.659	1.033	0.621	0.513	0.735
1965[1]	0.505	(NA)	(NA)	(NA)	(NA)	0.640	(NA)	(NA)
1960	0.515	0.488	0.480	0.836	1.058	0.612	0.529	0.697
1950	0.573	(NA)	(NA)	(NA)	(NA)	0.618	(NA)	(NA)
White								
1974	0.563	0.526	0.519	0.853	1.158	0.663	0.587	0.795
1970	0.514	0.484	0.476	0.769	1.027	0.611	0.486	0.741
1967[1]	0.491	0.461	0.455	0.675	0.982	0.613	0.489	0.719
Black								
1974	0.629	0.489	0.482	0.630	1.031	0.703	0.515	0.853
1970	0.523	0.437	0.430	(X)	0.805	0.682	0.514	0.825
1967[1]	0.535	0.445	0.440	(X)	0.935	0.640	0.471	0.779

B Base less than 75,000. NA Not available. X Not applicable.
[1]Revised.

Source: Current Population Reports, Series P-60, Nos. 9, 37, 59, 97, and 101.

SOURCE: Marquis Academic Media; SOURCEBOOK ON AGING, 1979.

Future cohorts of the aged will have a higher level of education and consequently a higher level of expectations. Table 9 shows the educational attainment of the population 65 years old and over and 25 years old and over, by sex from 1952 to 1990. In the early part of the century, only 10 percent of the population reach high school. By 2000, 70 percent of the elderly would have reached high school level, and 30 percent would have reached college level (Berghorn, Schaffer, 1981).

> "By the year 2000, it is estimated that the average educational level for those 65 and over will rise from an eighth grade to a twelfth grade level. This more educated and more articulated group is expected to see their problems as remediable, to accept societal responsibilities for amelioration of personal problems, to have higher expectations concerning the governmental and private agency contribution to their well-being, to become more vocal in their demands, and to join voluntary organizations to implement these demands.....This revolution of rising value-expectations has combined with the advances in medicine to focus attention on demands." (p. 79, Winston-Wilson, 1977)

EDUCATIONAL ATTAINMENT OF THE POPULATION 65 YEARS OLD AND OVER AND 25 YEARS OLD AND OVER, BY SEX: 1952 to 1990.

(Figures are of March of year indicated)

Sex and Year	Median School Years Completed			% High School Graduates		
	65 yr old and over	25 yr old and over	Ratio 65+ and 25+	65 and over	25 yr old and over	Ratio 65+ to 25+
Both Sexes						
1952	8.2	10.1	0.81	18.4	38.4	0.48
1959	8.3	11.0	0.75	19.4	42.9	0.45
1965	8.5	11.8	0.73	23.5	48.2	0.48
1970	8.7	12.2	0.71	28.3	55.2	0.51
1975	8.9	12.3	0.73	35.2	62.6	0.56
1980	9.7	12.4	0.78	37.9	65.4	0.58
1985	10.9	12.5	0.87	44.0	70.2	0.63
1990	11.9	12.6	0.94	49.4	74.2	0.67
Males						
1952	8.0	9.7	0.82	15.3	36.4	0.42
1959	8.2	10.7	0.77	18,1	41.3	0.44
1965	8.3	11.7	0.71	21.8	48.0	0.45
1970	8.6	12.2	0.70	25.9	55.0	0.47
1975	8.9	12.4	0.72	33.4	63.1	0.53
1980	9.4	12.5	0.75	36.3	66.5	0.55
1985	10.7	12.6	0.85	43.0	71.9	0.60
1990	11.8	12.7	0.93	48.7	76.3	0.64
Females						
1952	8.3	10.4	0.80	21.1	40.2	0.52
1959	8.4	11.2	0.75	20.4	44.4	0.46
1965	8.6	12.0	0.72	24.7	49.9	0.49
1969	8.8	12.1	0.73	30.1	55.4	0.54
1975	9.4	12.3	0.76	36.5	62.1	0.59
1980	9.9	12.4	0.80	38,9	64.4	0.60
1985	11.1	12.4	0.90	44.7	68.7	0.65
1990	12.0	12.5	0.96	49.9	72.3	0.69

SOURCE: Marquis Academic Media; SOURCEBOOK ON AGING, 1979.

2.) Certain Implications of the Aging Population

There are certain implications that an aging population carries. First of all, there will be a change in family structure. As life expectancy increases, some families will have three to four generations in their homes. The availability of a spouse will decrease as a consequence of the differential mortality rates between older men and women.

Changes in family structure can seriously affect the availability of informal supports. The availability of children to support their disabled parents may also diminish. As the population ages, the very old invalid may have children who themselves are retired or chronically impaired and thus are limited in their ability to assist the parent. Moreover, there is a trend toward greater mobility among family members. An elderly person may have children, but they may live too far away to be a source of support.

There will also be some effects on the health status of the society. An increasing number of elderly will need assistance with daily activities, and large families will need the necessary psychological, social, and economic supports.

Another effect that exists would be a change in living patterns. Today, there are only about 1 million individuals over 60 residing in nursing homes (about 5 percent). Most still prefer to live with their families or in the community. Many are also maintaining their own homes. Living alone requires stable financial resources such as social security, supplementary security income, and private pensions. Family income is positively related to the use of long-term care facilities. (Gefland, Olsen, 1980)

Then there is also a controversial concern about the rural and urban elderly population. Some research suggests that rural elder population has less economic stability and care. However, they experience a better quality of care, a more intimate environment that can enhance an individual's ability to maintain control over his or her life situation. Urban elder population, on the other hand, have services more readily available to them such as mass communication. However, the impersonal nature of an urban environment makes life lonely and isolated, and fear of crime further reduces the life space of inner-city residents. Therefore, it is very difficult to determine which pattern of lifestyle is more favorable to the elderly people. (Berghorn, Schaffer, 1981)

Furthermore, there are also the implications of employment and income. In 1977, only 20 percent of individuals between 60 and 70 were employed in white collar jobs. Low paying jobs mean lower social security benefits and inadequate pensions. However, Income Maintenance Programs, Medicare, Food Stamps, and housing subsidies have helped to raise the income floor level of the elderly. The median income for individuals over 65 rose by 35 percent between 1960 and 1970, and the number of individuals over 60 below the federally determined 'poverty' level dropped from 5.9 million in 1969 to 4.3 million in 1976. (Gefland, Olsen, 1980)

Finally, increased participation by women in the labor force may also decrease the amount of informal care. "The civilian labor force participation rate among women is expected to rise from 48 percent in 1977 to 57 percent by 1985 and exceed 60 percent by 1990." (p. 12, DHEW, 1981)

The above implications seem to project a dim view of the situation for our elderly population. Fortunately, the prevalence of functional

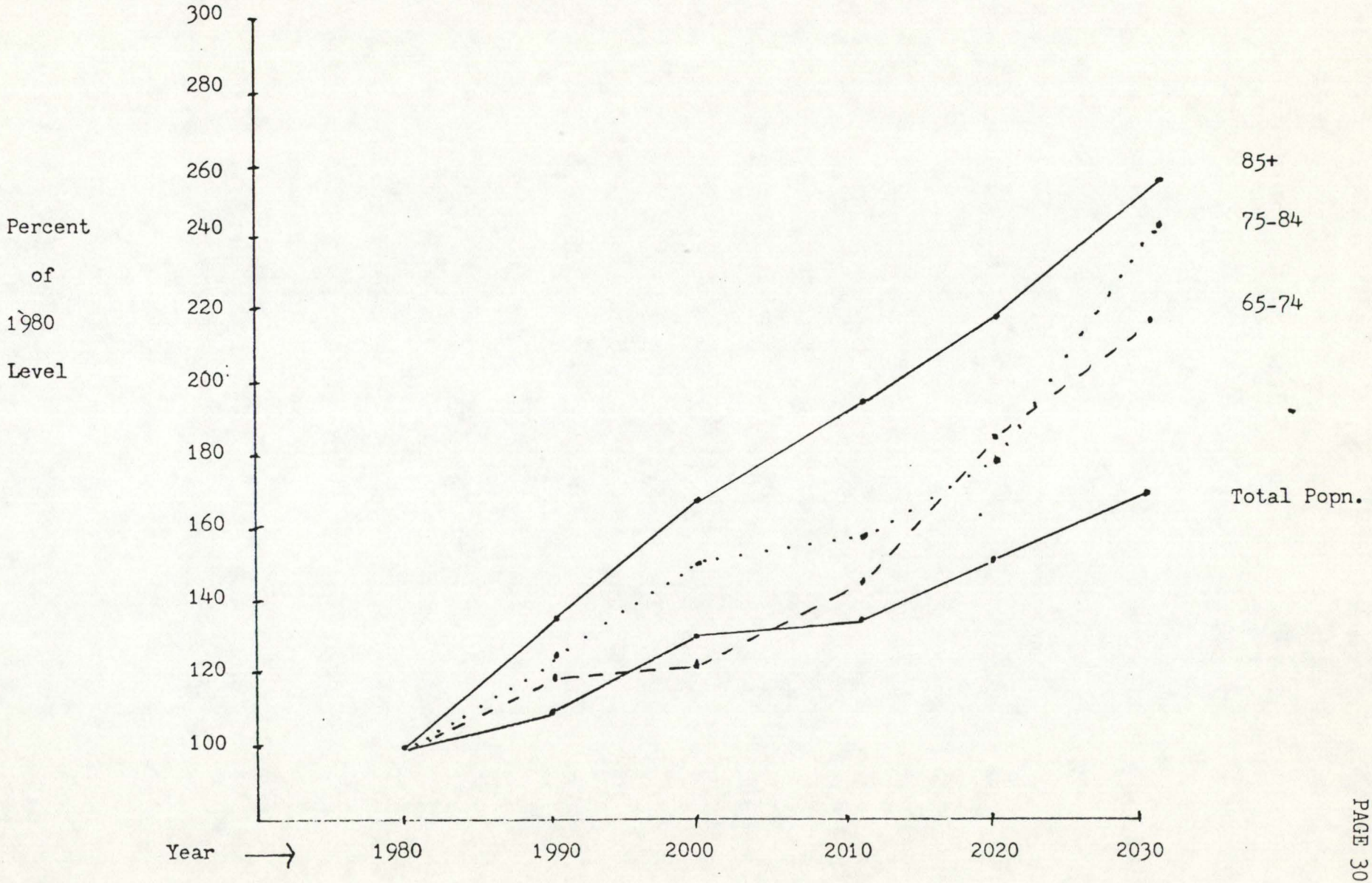
disability may not increase as fast as simple aged-based projections would suggest. As advances are made to improve treatment of chronic conditions, the health of the younger aged is likely to improve.

Another hopeful phenomenon is that poverty among the aged is declining. While this in itself will not reduce the need for long term care services, it may mean that more elderly will be able to afford to pay for services themselves.

3.) Projected Growth in Nursing Home Utilization

Table 10(a) shows projected growth of elderly population age group, 1980-2030; Table 10(b) displays the projected growth in nursing home utilization by age-cohort, assuming current use rates. Under these assumptions, the number of nursing home residents will increase 54 percent over the next 20 years and 132 percent by 2030. The largest users are all in the age cohorts of 75-84 and 85 and over. These estimates do not reflect any increased utilization due to changes in family structure.

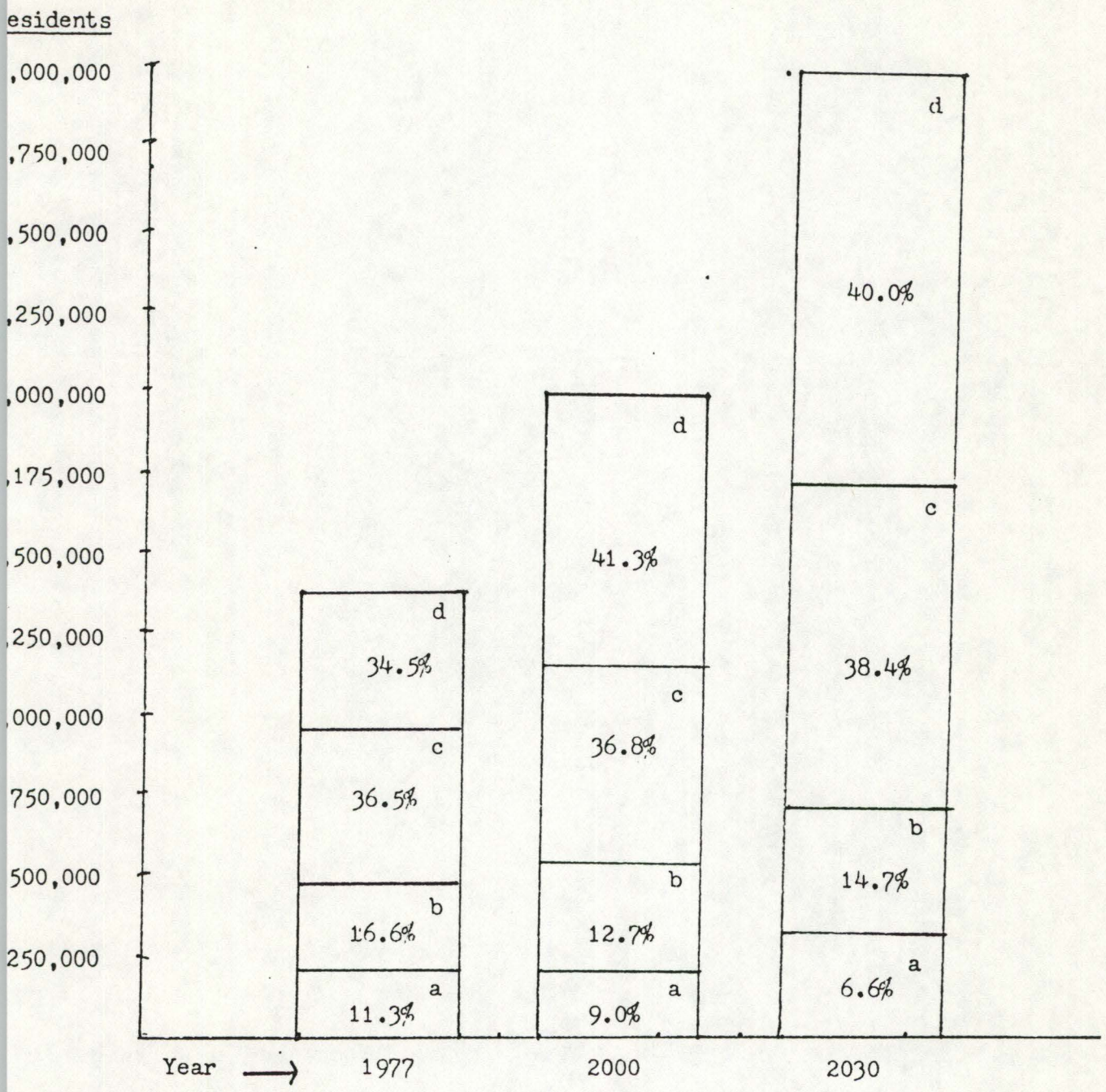
PROJECTED GROWTH OF ELDERLY POPULATION AGE GROUPS, 1980 - 2030



Source: (p . 11, DHEW, 1981.)

TABLE 9

PROJECTIONS OF NURSING HOME UTILIATION IF CURRENT TRENDS CONTINUE



Totals: 1,303,100 1,952,190 2,951,739

Age Groups: a 45-64 b 65-74 c 75-84 d 85+

Source: (p . 13, DHEW, 1981.)

4.) Conclusion

The data on nursing home utilization demonstrate that institutionalization results from a combination of functional disability and lack of such informal supports as a spouse or children. This suggests that a person's informal network is a critical variable affecting the need for formal long term care services in general. Unfortunately, there is no consistent national data on informal support systems for the functionally disabled. (DHEW, 1981)

We have discussed previously that a high 'dependency ratio' is expected as a cause of fiscal constraint to the society in financing public programs. This phenomenon could be controlled by a number of factors, such as a higher retirement age, higher fertility rates, or greater labor force participation among the 45-64 age group. One way of meeting growth needs in long term care services would be to provide a different mix of services aimed at caring for the functionally disabled in the community. There must, however, be an effective case management system to coordinate all services to provide a consistent pattern to such users. This paper will discuss such a system that the state of South Carolina is implementing as a viable aid to both the nursing home system and long term care in the community.

COMMUNITY SUPPORT SYSTEMS

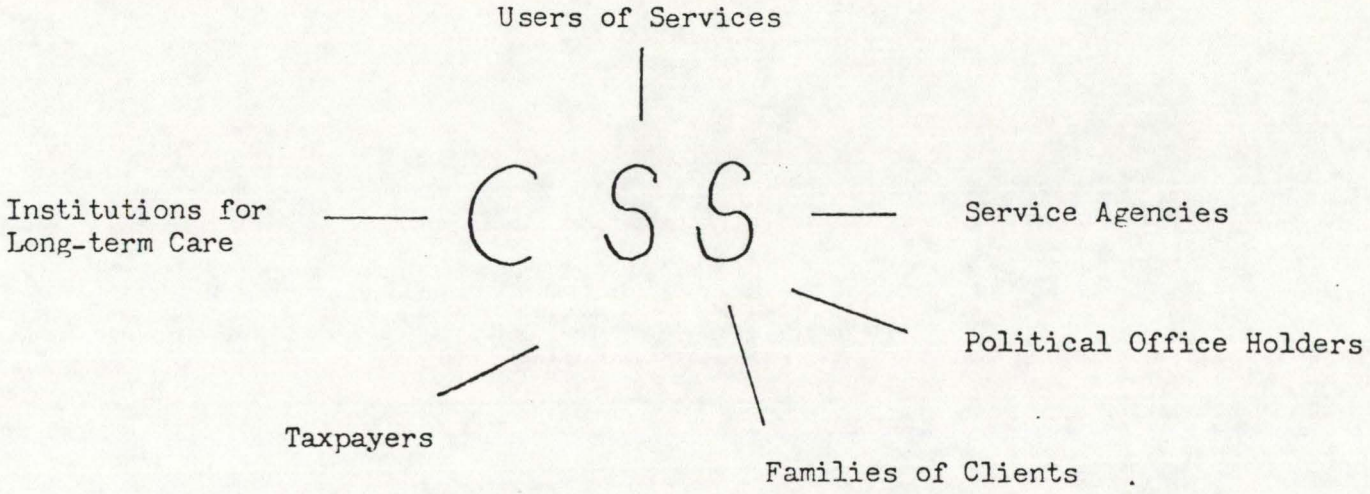
Long term services within the community support system (CSS) may vary from comprehensive care institutions such as nursing homes, to protected living arrangements, and finally to the family and the home. The community support system directly affects how money is spent, total time being spent, and the amount of volunteer effort needed to run the system.

The definition of CSS, according to Winston-Wilson, is:

> "a comprehensive network of services in a community designed to help older persons maintain that set of living arrangements which they desire and which seem most appropriate for their circumstances as defined by the older persons themselves, their families and health practitioners. Such arrangements often are defined as staying in the older person's own private residence. However, congregate living also requires a set of supportive services. The major outcome of establishing CSS is maximization of independent and dignified living by older persons." (p. 128, Winston-Wilson, 1977)

Table 11 illustrates individuals and organizations involved in the creation of CSS. As from the diagram we can see that the system depends on the whole involvement of the community: the taxpayers, the institutions, service agencies as well as political office holders. CSS is a supportive system provided by the community to help the aged maintain at home.

INDIVIDUALS AND AGENCIES PERCEIVED AS RELEVANT TO DECISIONS ABOUT COMMUNITY SUPPORT SYSTEMS FOR OLDER PERSONS



Source: (p. 128, Winston-Wilson, 1977.)

The diagram shows only the individuals and groups involved in CSS. However, individuals and organizations can be overlapping in some cases. That is, family members are also taxpayers; political office holders are usually members of a family, and so on. The users of services are the clients themselves, they may or may not have difficulties in making decisions about services. Service agencies do not include agencies which have inpatient beds and related facilities. Agencies such as home health, homemaker, meals-onwheels, and those who are capable of providing services to older persons in their own private homes or in other residential settings are considered as service agencies.

Inpatient institutions include general and special hospitals, nursing homes, and mental institutions. These institutions can serve as basis with which agencies having outreach programs can cooperate. Family members are a very important part of the CSS overall success. Family members are frequently caught in a dilemma that CSS can help solve. An elder person may need to stay at home and be in need of certain services. In such instances, time and other resources may cause conflicts. Taxpayers and office holders are usually more involved in payment of services. They may also play other overlapping roles such as family members, or persons in charge of service agencies.

Table 12 lists value themes according to individuals and organizations involved in making decisions about community suport systems for older persons. Such value themes are very broad and general, they represent what we feel are their major concerns for supporting CSS.

The users of services (clients) may have value themes such as freedom, progress, material comfort, activities and work. Service agencies and

institutions for long term care may be more concerned with humanitarian principles. While families of clients may have similar value criteria as the clients themselves. Taxpayers and political office holders may be more interested in seeing progress and efficiency, human mores, and other scientific and rationality principles.

The purpose of identifying value themes is basically to uncover potential and/or actual similarities and differences among the categories of interested parties as well as consider potential dilemmas within them. (Winston-Wilson, 1977)

LISTING OF VALUES THEME ACCORDING TO INDIVIDUALS AND ORGANIZATIONS INVOLVED IN MAKING DECISIONS ABOUT COMMUNITY SUPPORT SYSTEMS FOR OLDER PERSONS

Clients	Services	Agencies	Institutions for Long Term Care	Families of Clients	Taxpayers	Political Office Holders
Freedom	Humanitarian Concerns	Human Mores	Human Mores	Human Mores	Efficiency	Efficiency
Individual Personality	Others Not Clear	Humanitarian Concerns	Individual Personality	Freedom	Human Mores	Science and Rationality
Progress		Others Not Clear	Progress	Individual Personality	Freedom	Freedom
Material Comfort			Material Comfort	Progress	Progress	Progress
Activities and Work			Activities and Work	Material Comfort	Material Comfort	Material Comfort
				Activities and Work		Humanitarian Concerns

Source: (p . 133, Winston-Wilson, 1977.)

The community service system includes a variety of services. These services are organized under three headings: nursing homes, protected living arrangements, and the home.

Nursing Homes

Nursing homes are the major long term care institutions for the impaired and disabled senior citizens. Some 1,300,000 Americans, including 5 percent of those aged 65 and over, live in 18,900 nursing homes nationwide (p.15, DHEW, 1981). However, 20 percent of the elderly will spend some time in a nursing home before dying.

In 1979, nursing home expenditures amounted to $17.8 billion, an estimate that excludes many medical services, such as most physician services. Government expenditures accounted for 56.7 percent of this total. Private payments accounted for the remaining 43.2 percent. Table 13 presents estimates of nursing home care expenditures by source of payment. In the public sector, Medicaid pays for close to 50 percent of the expenses, and in the private sector, direct payment by clients account for half of the total expenses. The table shows that the overall distribution of nursing homes for the past seven years had been fairly stable.

CALENDAR-YEAR ESTIMATES OF NURSING HOME CARE EXPENDITURES BY SOURCE OF PAYMENT.

(Percent Distribution)	1973	1974	1975	1976	1977	1978	1979
Total	100%	100%	100%	100%	100%	100%	100%
Public Payments	51.3	53.7	56.2	55.6	57.2	57.1	56.7
Medicaid	42.9	45.8	48.1	47.6	49.0	49.5	49.3
Medicare	2.6	2.8	2.8	2.9	2.8	2.3	2.1
Veterans Admin.	1.6	1.6	1.7	1.8	1.9	1.8	1.7
Other Public Funds	3.2	3.4	3.4	3.2	3.3	3.4	3.4
Private Payments	49.6	46.2	43.8	44.3	42.7	42.8	43.2
Direct Payments	48.6	44.8	41.2	42.3	42.9	41.4	42.0
Insurance Benefits	.23	.74	.77	.79	.70	.69	.65
Other Private Funds	.72	.64	.60	.61	.59	.59	.60

Source: Health Care Financing Administration (p . 16, DHEW, 1981)

Medicaid is the major public source of financing, accounting for 87 percent of the $10.1 billion in public expenditures. (pp.16, DHEW, 1981) To be eligible for nursing home care under Medicaid, individuals must have income and assets below state-established ceilings. Two types of nursing homes are eligible for Medicaid reimbursement: (a) skilled nursing facilities (SNFs), which provide 24-hour skilled nursing care under the supervision of a physician, and (b) intermediate care facilities (ICFs) , which are less intensive and are intended for patients who require care only on an intermediate basis.

Medicare accounts for another 4 percent of public nursing home expenditures. The coverage is limited to 100 days per spell of illness for beneficiaries who have been hospitalized for at least 3 days. Other public sources, such as the Veterans Administration and various state and local programs, comprise the remaining 9 percent of public expenditures for nursing home care. (p.17, DHEW, 1981)

The predominant source of private funding is direct payments by residents and their families. These payments account for 97 percent of all private revenues. Third party payments account for only 1.5 percent; other private payments, such as charitable contributions account for another 1.5 percent.

The private insurance sector is more biased toward providing insurance coverage for hospitals rather than for nursing homes. Private insurance accounts for only 1.5 percent of private nursing home, but it accounts for 74.5 percent of private hospital expenditures. The private insurance sector has decided that nursing home services at this point in time are not an insurable risk, except for some short-stay acute patients.

Protected Living Arrangements

Protected living arrangements are for those elderly who live outside of institutions and who are unable to maintain an independent existence, or who do not have family members to take care of them. Personal and domiciliary care facilities, foster care homes, and congregate housing provide protective settings for the elderly and disabled.

A personal care home provides personal care services, including assistance with activities of daily living (ADL) such as bathing, eating, and ambulation. The National Center for Health Statistics set standards that in order to be classified in their bulletin, a personal care home must provide at least three or more services to each client.

A domiciliary care facility provides a lower level of care - room, board, housekeeping, supervision, and some degree of ADL assistance. In order to be classified in the National Center for Health Statistics, a dormiciliary care facility must provide at least one or more services to each client. These facilities, which are commonly licensed by state departments of social services, are not usually allowed to provide medical services.

Personal and domiciliary care homes are not covered under either Medicaid or Medicare. However, supplemental Security Income (SSI) provides payment assistance to the aged, blind, and disabled. In addition to the federal SSI, 31 states also supply payment assistance to persons living in such arrangements. (p.18, DHEW, 1981)

A foster care home (FCH) is usually " a private home that is owned and occupied by an individual or family who offers a place of residence, meals,

housekeeping services, minimum surveillance, and personal care." (p.18, DHEW, 1981) Sponsors are paid a monthly fee, and states may use their monies under Title XX of the Social Security Act to cover foster care. Every sponsor usually has the ability to match the needs of their clients individually. It is this personal aspect which most differentiates FCHs from domiciliary care facilities.

Congregate housing for the elderly is very hard to define. It is more or less an age-segregated housing type that provides an on-site meal program, minimal surveillance, and shelter. Most residents are functionally or emotionally independent but benefit from assistance with meal preparation and social interaction with other residents.

Several programs under the Department of Housing and Urban Development (HUD) provide funds to construct housing or to subsidize rents for the elderly and for low and middle income families. They are: Section 8, which provides rental subsidies to low and moderate income families; Section 202, direct loans for construction of housing for elderly and handicapped persons; Section 231, which insures lenders against losses or mortgages used for rental units for the elderly and handicapped; and Section 236, mortgage insurance and mortgage interest subsidies for rehabilitation and new construction of rental and cooperative housing for low and moderate income families. (p. 18, DHEW, 1981)

Retirement communities are basically for a minority group of wealthy elderly who can afford the expenses of a distinct group of services. Retirement communities provide environmental advantages similar to those of congregate housing in that social, medical, commercial, recreational, and transportation services are easily accessible.

Family and The Home

Many disabled elderly need some services but do not require institutionalization nor the protected housing arrangements previously discussed. These individuals can live in their own home or the home of relatives and friends. However, they can benefit from community based services such as home health care, personal care, homemaker and chore services, monitoring, home-delivered or congregate meals, and adult day care.

1.) Home Health Care

Medicare funds medically oriented home health care, including skilled nursing, physical therapy, occupational therapy, speech therapy, home health aides assistance and medical supplies and appliances provided in the home. In order to qualify, a beneficiary must be confined to the residence (homebound); be under the care of a physician; and need skilled nursing care, physical, occupational, or speech therapy on a part-time or intermittent basis. (p.19, DHEW, 1981)

An average number of 23 home health visits per person was provided in 1977. Medicare will reimburse only for services by certified Home Health Agencies (HHAs). Participating HHAs must provide skilled nursing and at least one other home health service. HHAs must meet all federal, state, and local licensure and certification requirements. (p. 19, DHEW, 1981)

In FY 1978, Medicare home health expenditures totaled $520 million, 2 percent of total Medicare expenditures. Between FY 1976 and FY 1978 total benefits increased 62 percent. (p. 19, DHEW, 1981)

Medicaid also funds medically oriented home health services for the

aged and disabled poor. Most home health services vary from state to state; however, all states must provide the following home health benefits: nursing services, home health aide assistance, medical supplies, equipment, and appliances. States have the option of covering other home health services such as physical, occupational, and speech therapies, medical social services, and personal care services. The law governing home care is less restrictive under Medicaid than under Medicare. For example, a person need not be homebound or require skilled care to receive Medicaid benefits.

In FY 1978, Federal and state home health expenditures totaled $211 million, 1 percent of total Medicaid dollars. (p.20, DHEW, 1981)

2.) Personal Care Services

Personal care services refer primarily to assistance with basic activities of daily living. It may also include other supportive services such as assistance in routine household chores. States may pay for this type of care in a recipient's home under Medicaid if the services are prescribed by a physician in accordance with a plan of treatment and are provided by an individual who is qualified, supervised by a registered nurse, and is not a member of the recipient's family.

There are currently two major issues that concern the public regarding personal care services. The first is the question of who the real employers of such providers are. If these providers are not self employed, then either the state or the beneficiary will be their employers. The outcome of such disputes will have effects on the cost of services in terms of applicability of minimum wage, social security benefits, unemployment insurance, and so forth. Another significant issue is whether these providers are, or can be, adequately supervised.

Medicaid guidelines specify that, to be reimbursable, personal care services must be related to health needs and disabilities. In reality, personal care services sometimes go beyond to other necessary services such as homemaker and chore services.

Title XX of the Social Security Act also covers some personal care. However, only 6 percent of all Title XX funds are used for health related services, a category which includes personal care, and only 25 percent of this amount (1.5 percent of total Title XX expenditures) is spent for aged recipients. Title III of the Older Americans Act of 1965 funds home care and community-based social services similar to those available under Title XX. The only eligibility is that a person be at least 60 years old. (p. 21, DHEW, 1981)

3.) Homemaker and Chore Services

Homemaker and chore services include house cleaning, minor repairs, shopping, errands and basic financial management. These services are intended to maintain elderly persons in their own homes and avoid premature institutionalization. The ideal services are those supervised either by a nurse, a social worker, or other professionals.

Medicare does not cover homemaker services. Some state Medicaid programs cover homemaker services under the personal care option. Title III of the Older Americans Act authorizes grants to states for services which may include homemaker care, and states may use Title XX social services grants for homekeeping, homemaker, and home management services.

4.) Monitoring Services

Monitoring services are intended for those elderly persons who need

very minimal services such as friendly visiting, daily telephone calls, or periodic inquiries. Most monitoring programs are initiated by volunteer community groups. Limited funds are provided under Title III and Title XX programs.

5.) Home-Delivered and Congregate Meals

Home-delivered and congregate meals both provide meals for the elderly who cannot prepare their own meals at home.

Home-delivered meal programs are usually organized and funded by private nonprofit organizations. Because of the large demand for such services, most programs screen applicants to identify those who are truly homebound and exhibit the greatest need. There is some funding available under Title III and Title XX of programs.

Congregate meals are served in communal locations such as housing projects, senior centers, churches, and schools. Under Title III, all persons aged 60 and above who cannot provide meals for themselves are eligible. As with home-delivered meals, recipients contribute toward the cost of the meal if they are able.

Both home-delivered and congregate programs provide benefits beyond nutritional meals, such as social contacts and information, and referral to other health and social services.

6.) Adult Day Care

Adult day care programs enable persons to stay at home and maintain their social ties in the community. They also encourage families to care for elderly dependents by providing relief from the burden of constant care.

Most programs provide lunch, general nursing, and personal hygiene. In addition, special diets, dietary counseling, psychiatric services, physical, occupational, and speech therapies, and transportation may be available. There are approximately 700 adult day care programs in the U.S.

There are very limited funds for day care services available from Title XX and Title III programs. In addition, community organizations have provided funding and volunteer labor.

CURRENT PROBLEMS OF THE LONG TERM CARE SYSTEM

The long term care system today suffers basically from three problems: high cost, inadequate accessibility and poor quality of services. (p. 23, DHEW, 1981) Each of these problems will be briefly discussed below.

Increase in Public and Private Costs

The increase in costs of long term care is most obviously reflected in federal and state budgets. The Congressional Budget Office (CBO) estimated that total national spending on long term care was between $18 and $20 billion in FY 1976. (p. 23, DHEW, 1981) The increase in nursing home expenditures has been particularly rapid, rising from $7.2 billion in 1973 to over $17.8 billion in 1979. Between 1973 and 1979, nursing home expenditures grew by 148 percent, and it was the fastest growing component of personal home health care expenditures in 1979.

The public sector reflected the rise in nursing home costs in an increase in the total public expenditures from $3.6 billion in 1973 to $10.1 billion in 1979. This expenditure growth is a function of both increases in the cost per day and in the number of days used. The number of residents increased 21 percent compared to a 12 percent growth in the elderly population. (p. 24, DHEW, 1981)

The private sector also reflected an escalation in its health expenditures for long term care. In FY 1976, the Congressional Budget Office estimated that 40 percent of the total cost of long term care services was paid directly by clients themselves. (p. 24, DHEW, 1981) The direct out-of-pocket expenditures accounted for almost all private payments; insurance payments and charitable contributions accounted for only about 3 percent of all expenditures.

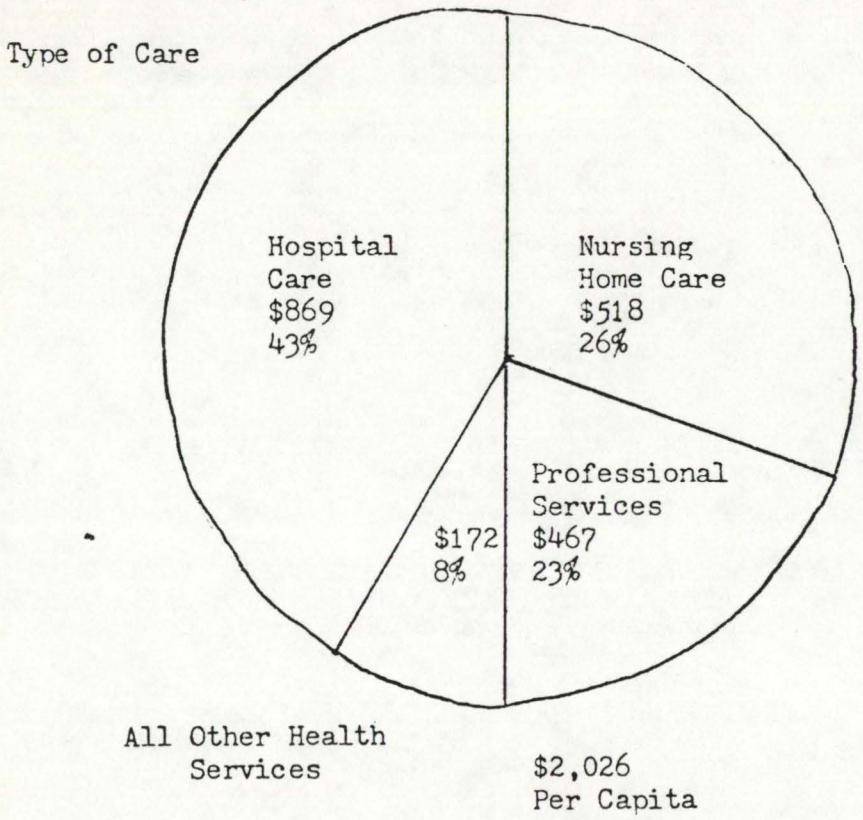
If the cost of long term care continues to grow faster than the income growth of the elderly, we can expect in the future that more elderly will exhaust their resources and have to convert to medicaid for funding.

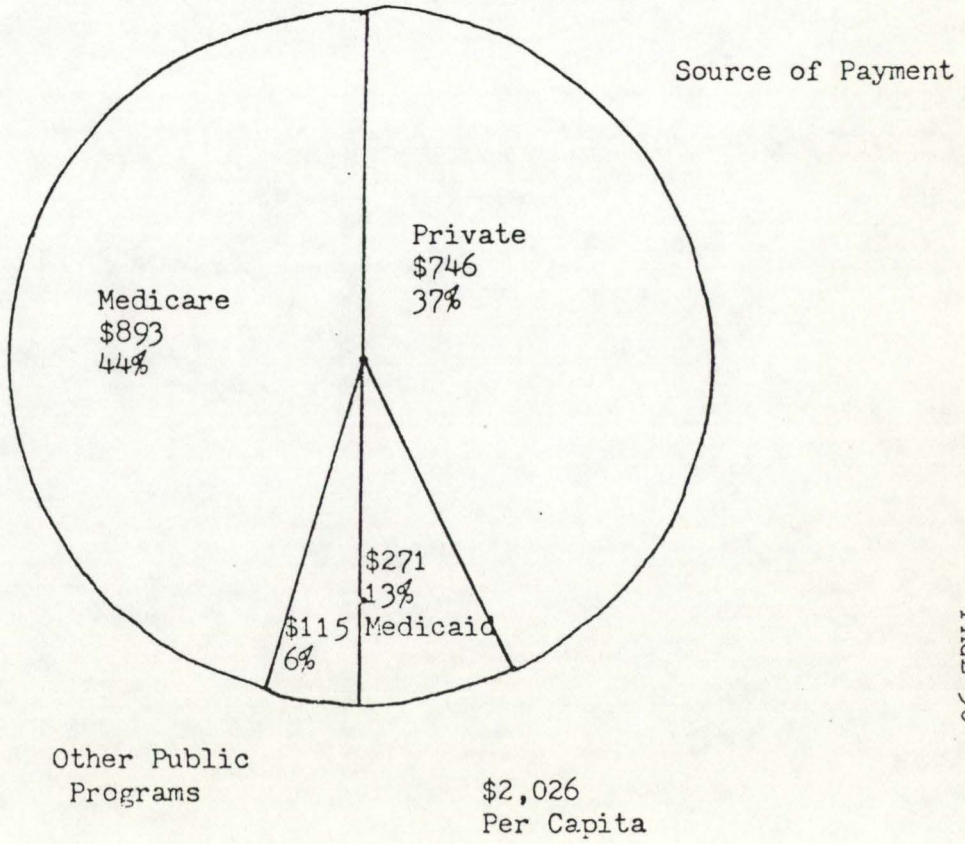
> "If present utilization rates continue, the total nursing home population will rise 54 percent over the next 20 years and will more than double over the next 50." (p. 24, DHEW, 1981)

Moreover, due to the overall aging of the population, the need for long term care services may become a burden to a proportionately smaller working population, thus making it even more difficult for government to maintain services.

The following table shows the per capita health care expenditures for the elderly by type of care and source of payment in 1978.

PER CAPITA HEALTH CARE EXPENDITURES FOR THE ELDERLY BY TYPE OF CARE AND SOURCE OF PAYMENT: 1978





Source: Health Care Financing Administration
(P. 51, DHEW, 1981)

Inadequate Access To Service

Limited access to services in the long term care system is due to the following four reasons:

1. Medicaid eligibility criteria is a major cause of a bias toward institutional and skilled medical care;

2. There is discrimination against medicaid and heavy care patients;

3. The availability of long term care services varies greatly in different geographical areas;

4. Non-institutional long term care services are funded by multiple programs in the community that lack an overall coordination.

The first reason for a limited access to services suggested by numerous studies states that current public programs provide a much greater support for institutional care than for community services. These studies have shown that a substantial proportion of nursing home clients could be maintained at home or in other noninstitutional settings if support services were available. Inappropriate institutionalization can create a loss of privacy, and lack of contact and normalcy with the outside world.

Medicaid eligibility criteria were suspected to be a major cause of this bias. In many states, it is easier to obtain Medicaid benefits if the person stays in a nursing home than if he stays at home. To be eligible for medicaid and still stay at home, the person's income level has to be very low, so low that he is receiving public assistance. Or, his medical expenses has to be so high that it reduces his income level to subsistence standards.

Moreover, Medicaid program is an open-ended entitlement program that provides the richest source of funding; whereas social service programs are closed-ended grants where funding has not increased as rapidly as medicaid

programs. This is the second reason why Medicaid has largely shaped the long term care delivery system.

Another factor contributing to this inappropriate institutionalization is that spouses and families are not held financially responsible for medicaid clients if they stay in a nursing home. Conversely, when the institutionalized person has adequate income, current policy allows him to set aside some income for support of the spouse or family. However, the amounts allowed are limited to public assistance levels and may not be adequate to maintain a household. Thus, current practice may force the noninstitutionalized spouse to enter an institution as well.

Finally, most of our current policies put more emphasis on the medical model of care: services that physicians and nurses provide, even though many clients may not need such skilled care. Policymakers choose this emphasis because medical needs are clearly more politically acceptable. Basic supportive services - such as meal preparation, laundry, and housekeeping - are reimbursed only if they are provided in a nursing home or hospital, but not in the home. Many fear that expenditures would increase uncontrollably if medicaid or medicare paid for supportive nonmedical services.

The second reason for a limited access to services in the long term care system may seem to contradict with the first reason initially: namely, that there is discrimination against Medicaid and heavy care patients. Actually, nursing homes give preference to private pay and 'light care' patients simply because of a shortage of beds. The result increasing number of elderly persons who are in hospitals when they they should only be in a nursing home.

The availability of long term care services also varies greatly among states. The nursing home bed supply varies from 23 beds per thousand elderly in Florida to 118 beds per thousand elderly in Nebraska. (p. 26, DHEW, 1981) Most variations in resources, moreover, do not appear to be related to variations in needs. For noninstitutional home health services under medicaid, Title XX and Older Americans Act, states are also given great discretion in their extents of coverage.

The last reason - multiplicity of programs - is a very serious problem, and this paper attempts later on to discuss about a statewide policy that is being implemented in South Carolina to combat the problem of disunity and inconsistency in the availability of services.

Although the financing of nursing homes is dominated by Medicaid, noninstitutional long term care services are usually funded by multiple programs under private organizations, federal, state, and local government agencies, with no single entity having overall responsibilty for long term care.

> "Several programs finance alternatives to nursing home care for the elderly. There is some overlap in these types of services, and each program has its own legislatively mandated eligibility requirements, benefit package, provider participation restrictions, administrative structures, and service delivery mechanism. At every level of government, each program tends to operate fairly independently of the others. Furthermore, no single agency or organization is assigned responsibility for coordinating the care of the individual recipient. As a result, the disabled elderly face a complicated and confusing service system in which it is difficult to coordinate a comprehensive package of noninstitutional services." (p. 27, DHEW, 1981)

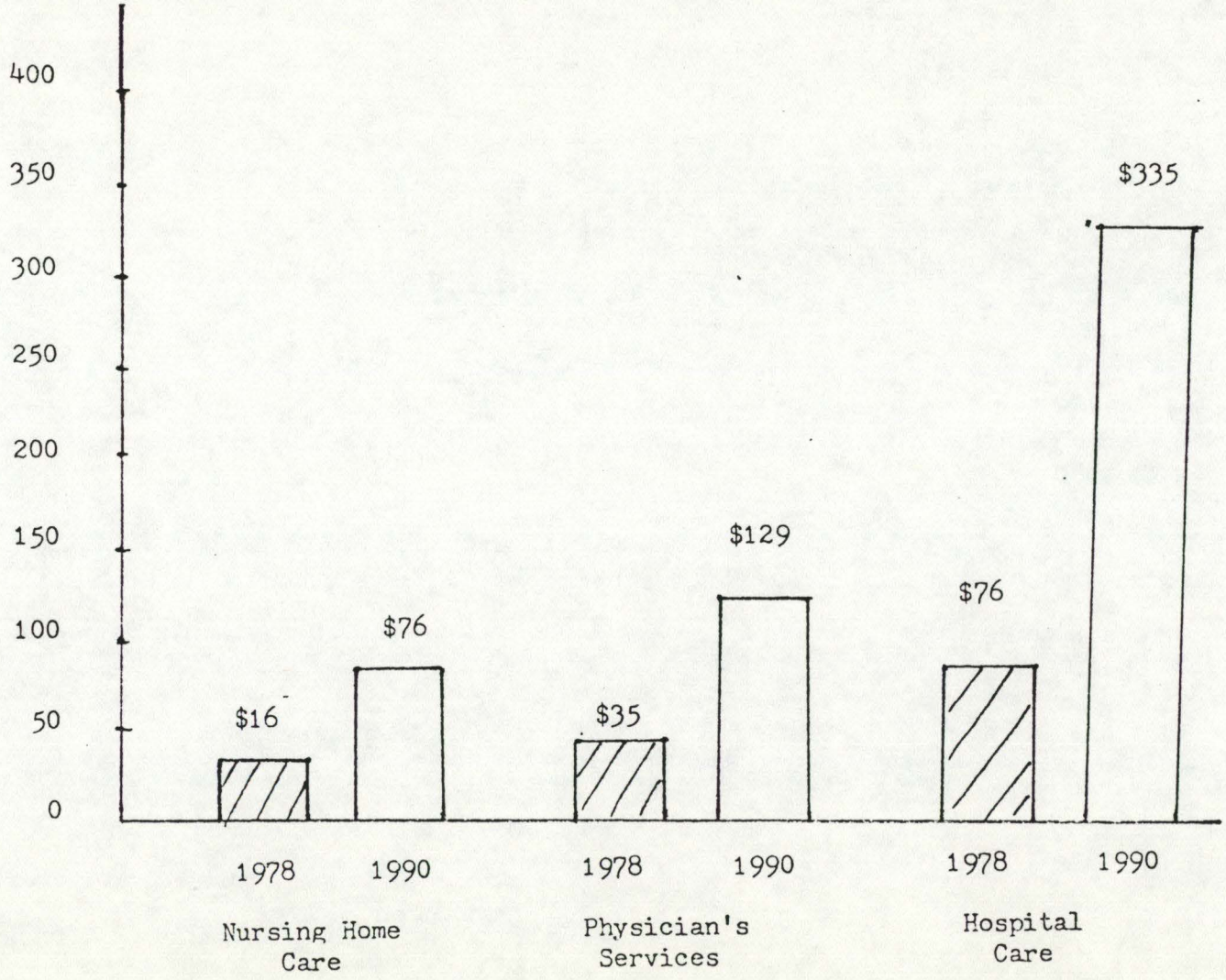
Under current programs, many people who require some form of long term care, particularly noninstitutional ones, will need to rely on friends and families to provide for them. If the availability or the willingness of

friends and families to provide for care decline in the future, the need for formal long term care services will increase.

Inadequate access to services can contribute to high costs as well as poor quality of services. The wrong services will be provided to the wrong people; and lack of coordination and support will lead to more formal care, which in turn will lead to a rise in costs. When services are provided in an uncoordinated, inconsistent manner, the quality of services can never be too promising.

The following tables show the projected expenditures for health services by type of service, and the projected use of health services by the elderly in 1978 and 2000.

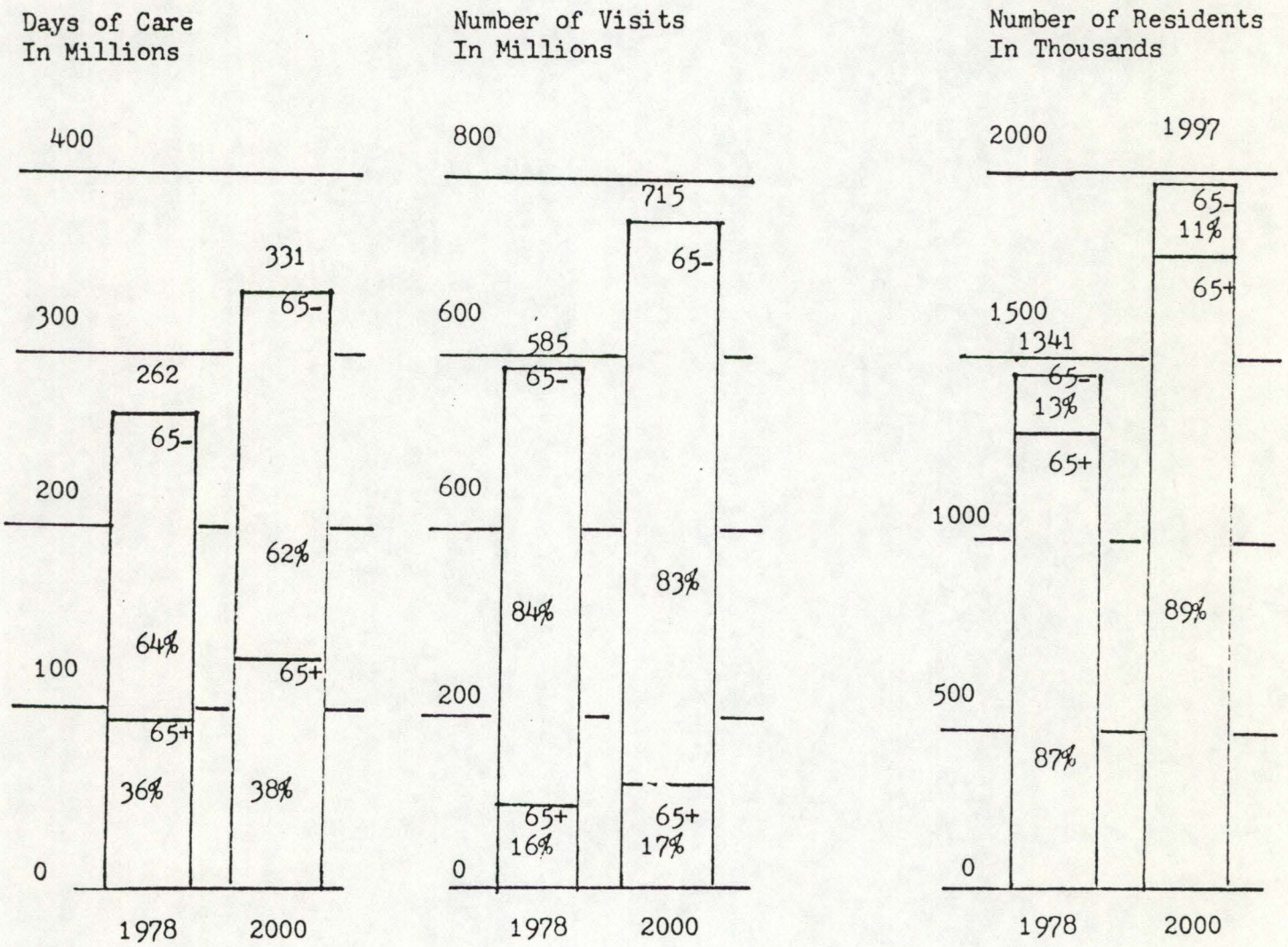
PROJECTED EXPENDITURES FOR HEALTH SERVICES BY TYPES OF SERVICES:U.S. 1978 AND 1990



Source: Health Care Financing Administration (p. 53, DHEW, 1981.)

TABLE 15

PROJECTIONS OF THE USE OF HEALTH SERVICES BY THE ELDERLY:
1978 and 2000



Source: National Center For Health Statistics (p. 55, DHEW, 1981.)

Poor Quality of Long Term Care Services

Federal and state governments have been trying to combat scandals concerning the quality of nursing home care in recent years through regulatory measures. However, the major concern is the quality of care in noninstitutional community settings because of the decentralization of the delivery system.

Problems with the quality of long term care include fire safety, training of staff, lack of physicians, overmedication, and other human elements.

Fire safety standards in federally regulated homes have been substantially improved in recent years. Group fires have not been reported in such homes since 1976. However, fire safety standards have not been updated in personal care and boarding homes. Such homes are usually subjected only to local jurisdiction and local authorities may be too anxious to preserve needed facilities and be lax in enforcing the fire codes. (p. 28, DHEW, 1981)

The recruitment, retention, and training of staff is unquestionably one of the most important problems. The turnover rates for nurses aides run as high as 75 percent annually. An estimated 25 percent of all available positions in nursing homes are vacant at any one time. (p. 29, DHEW, 1981) The severe nursing shortage is complicated by the problems of low pay, inadequate training, attractiveness of hospitals, and flexible working hours elsewhere.

Lack of adequate supply of physicians is another factor that contributes to poor quality of long term care. The abandonment by

physicians in rural areas is well documented. Physicians also find it very difficult to accept medicare/medicaid patients because of regulatory measures in reimbursement. In the long run, it is best to educate medical students in geriatric training and in the use of nursing homes. In the short run, physician assistants and nurse practitioners may be able to partially substitute for physicians.

Overmedication is a major management solution when there is a scarcity of staff and physician s. HCFA has recently required a monthly drug review by a pharmarcist, but the problem arises when the pharmarcist is also a drug supplier. To date, the problem is still very widespread. (p. 29, DHEW, 1981)

Human problems include lack of privacy, inadequate visiting hours, and rigid and arbitrary schedules. Nursing home residents feel the discomfort of regimentation that characterizes large institutions.

Finally there is the problem of inappropriate placement of mentally ill clients from hospitals into nursing homes. Although such an arrangement may be reasonable for the individual patient, it may be difficult for nursing homes to absorb a great number of them. A large proportion of them in a single institution may create the feeling of a mental hospital, thus destroying the normal homelike atmosphere essential to a nursing home. (p. 30, DHEW, 1981)

COMMUNITY SUPPORT SYSTEM AS A VIABLE ALTERNATIVE TO INSTITUTIONAL CARE

One of the major themes in recent years in long term care policies is the emphasis on in-home and community-based services. It has been well documented that a sound community support system can avoid the following problems: inappropriate institutionalization, inadequate care for the disabled in the community, inappropriate arrangements for the family, and excessive public expenditures. (p. 31, DHEW, 1981)

The Department of Health, Education, and Welfare has published some research findings concerning the expansion of community support system. These policy-relevant research questions are essential to our understanding of how noninstitutional services can serve as a viable alternative to long term care.

Research Question (1) : Shortage of Nursing Home Beds and its Consequences

The first research question concerns the shortage of nursing home beds and its consequences. The findings done by DHEW are that: (a) There is a shortage of nursing home beds in parts of the country and people can not gain admission to nursing homes for that reason. (b) The shortage is more obviously seen among Medicaid patients; not much is known about Medicare patients. There seems to be no shortage among private pay patients. (c) This shortage is likely cause the problem of placing heavy care patients backed-up in hospitals and may have disastrous effects on the quality of care in some homes. (p. 32, DHEW, 1981)

From an economic point of view, bed shortage is identified when the number of people who seek nursing home admission at a certain price is

denied due to an inadequate supply of beds. From a planning point of view, bed shortage occurs when the number of persons who need nursing home care are unable to obtain it. No matter from what point of view, however, it is a known fact that in recent years the growth in the number of nursing home beds has not kept pace with the growth in user population. Between 1973 and 1977, the nursing home bed supply increased 5.6 percent compared to a 12.7 percent increase in the population over 65. (p.32, DHEW, 1981)

There are several explanations for the shortage: firstly, more Medicaid eligibles want nursing home care than states can support. Also, many states have transferred mentally retarded clients from large institutions to nursing homes. Further, most state Medicaid programs do not provide an adequate amount of services other than nursing home care. Finally, instead of choosing income eligibility policies to control nursing home applicants, states have chosen reimbursement and certificate-of-need policies to restrict the supply of nursing home beds. (p. 35, DHEW, 1981)

The consequences of a bed shortage situation can range from discrimination against public low-payment, and heavy care patients; to a deterioration in quality of care and physical surroundings without suffering any loss of revenues.

Research Question (2) : How Can Community Support System Alleviate the Problem

Findings from DHEW studies show that between 10 and 40 percent of the elderly residing in nursing homes can be placed back into the home setting if appropriate community support system is available. Most of these estimates, however, are based on medical criteria for judging appropriate placement. When other factors such as social, psychological, and economic

factors are included, the estimate would be significantly reduced.

One major area that should be noted with deinstitutionalization is housing costs. Nursing homes do provide the benefit of housing that many elderly persons lose by the time they enter a home. The costs of replacing such housing for clients who return to the community can be significant.

Research Question (3) : Can Preadmission Screening and Assessment Mechanisms Identify High Risk Populations Who are in Need of Services?

Research findings have shown that preadmission screening and assessment methods vary too greatly to have a consistent pattern of identifying high risk populations. Moreover, the accurate placement of an individual is too critical to be treated objectively. In other words, there are no clear norms relating the level of functioning or other characteristics of an individual to specific services or settings. (p. 35-37, DHEW, 1981)

The basic aim of assessment measures is to have accurate placement for an individual, particularly in the community setting. However, the assessment methods used vary greatly among programs. DHEW sums it up as follows:

> "The assessment methods are designed to measure everything from social resources to health-related variables to indicators of client functional status. Further, some projects rely solely on clinical assesments by a social worker, nurse, physician, or a combination thereof, while others also introduce formal assessment instruments." (p. 36, DHEW, 1981)

As the first part of this chapter indicated, people need nursing home care for a variety of reasons - chronic illness, functional disability, and lack of family and friends. Moreover, different homes may satisfy different needs of individuals, including: housing, nursing care, nutrition, and

personal care. Therefore, there is no particular pattern of assessment methods that can identify population that are at high risks. However, preadmission assessment can improve appropriate care and more use of community support system.

Research Question (4) : Can Case Management Solve System Fragmentation and Improve Cost-Effective Use of Long Term Care Services?

Not surprisingly, the findings conclude that there is insufficient data and lack of standards concerning case management systems to fully determine their effects on cost-effectiveness and system fragmentation:

"Case management systems can vary greatly in their scope of responsibilities, organizational arrangements, and degree of authority and/or influence.
The effectiveness of the case management components of state programs and ongoing demonstration projects has not been systematically evaluated.
Since models vary widely, so do the costs of case management services."
(pp. 37, DHEW, 1981)

Little research is available concerning the cost-effectiveness of case management programs because case management is not an exclusive program of its own that can be determined independent fo other programs. For the most part, existing case management programs are not comprehensive. Some coordinate social services only, others may coordinate only health services. The Community Long Term Care project in South Carolina that this paper focuses on is the beginning of a gatekeeper approach with preadmission screening and eligibility/ placement authority over all services. The following table shows what a comprehensive case management program should include.

COMPONENTS OF CASE MANAGEMENT PROGRAMS FOR LONG TERM CARE

Process/Function	Scope of Responsibility	Organization/ Arrangement	Authority and Influence
1.) System Oriented Functions	1.) Health Care Services	Free standing	Control funding, eligibility and reimbursement
Data Collection . Needs survey . Resource profiles	Acute Anbulatory Medical Care	(Case management not part of direct service agency)	Control cost (rate setting)
Planning	Acute medical care		Influence Policy
Service Development	Nursing home care	(Special unit for case management within larger organization)	. Review/ comment on plans
Quality assurance/ monitoring	Home health care		. Review comment
Agency linkages and system coordination and/or determinator of eligibility (gatekeeper)	Day health care'		. Application
Advocacy (system-wide)	Respite care		. Political Advocacy Activity
2.) Client Oriented Functions	Hospice care		
Assessment	2.) Social Services		
Referral	Homemaker/chore		
Direct Service	Transportation		
Reassessment	Nutrition Counseling		
Advocacy (client)	Meal programs		
Case coordination	Protective services		
	Social day care		
	Other social services		
	3.) Housing Services		
	Rest homes		
	Domiciliary care		
	Foster care		
	4.) Geographic Area		
	State City		
	Regional ' Other		

(Source: p. 39, DHEW, 1981)

Research Question (5) : Can Noninstitutional Services be of Use to Informal/Home Care?

Currently, this topic is still under debate. There is very little well-controlled evidence to show how much expanded home care can benefit family responsibilities.

Families assume the major caring function for disabled elderly who live in the home setting. Between 60 and 80 percent of the care the disabled in the community now receive is provided informally by a spouse, other relatives, and/or friends.

It is very common for families to wait till a 'crisis stage' occurs in which the situation is so unprepared that formal care structure seems to be the only way out. There is no sufficient research to show the consequences when a set of services are provided early enough in the situation that can fully test its implications on family responsibilities.

Research Question (6) : The Cost-Effectiveness of expanded Community Support System

Summary findings by DHEW shows the following results: (1) Community support of individuals is cost effective to a significant proportion of clients. However, as a client's disability level increases, a breakeven point occurs, past which it is more expensive to maintain that person in the community system than in a nursing home. (2) A broad coverage of such a system would probably go to a new population rather than substituting for more expensive nursing home care. More than likely, such a coverage would increase public expenditures. (3) The community support system does help to lower mortality rates and increase life satisfaction among clients who receive them. However, there is not much relationship between that and functional abilities among clients. (p. 42, DHEW, 1981)

CONCLUSION

This chapter serves as an overview of our elderly population, focusing primarily on their health conditions and their needs for long term care. Our elderly population is definitely growing at a rapid pace. Already, there are predictions that a smaller work force would eventually have to support the large population over 65 years of age. Such a phenomenon means not only that the need for long term care will increase (it is estimated that the number of nursing home residents will increase by 54 percent over the next 20 years), but also that there will be a rise in costs of public programs.

Certain public policies and programs are discussed in the appendix: Area Agencies on Aging, Medicare/Medicaid, Social Security benefits, plus other income and health policies and programs. There is also a reference to government funding sources, and a brief reference to the proposed fiscal budget for the aged in 1980.

A sound community support system is viewed as the best viable alternative to institutionalization. Even though the research done on the issue by DHEW seems to be quite neutral, it can still serve to supplement nursing home care in the long run. The community support system is not observed as to take over long term institutional care, rather it is to compliment nursing home care so as to provide the most appropriate services to the clients and the most cost-effective method to public expenditures.

One of the major weaknesses in most community support system is the lack of coordination or consistency among the numerous providers of services. Such a situation can easily lead to duplication of services, and

inappropriate placement of clients in services. The Department of Health, Education, and Welfare has documented the need for a gatekeeper to provide preadmission case management to clients so as to bring to them appropriate services within the community.

South Carolina is currently implementing a statewide project to combat such inconsistency and fragmentation in our long term care system. A Community Long Term Care Council (CLTC) is set up to provide case management for clients and services. A demonstration project has successfully been implemented in a three-county area: Union, Spartanburg, and Cherokee. There is ongoing research to evaluate and monitor this demonstration. Ten more projects are now being implemented throughout the whole state.

CHAPTER III - A CASE STUDY IN PROGRAM IMPLEMENTATION - CLTC, SPARTANBURG COUNTY

GENERAL PURPOSE OF CLTC

The Community Long Term Care (CLTC) is a demonstration project of services and research to provide better community-based health care for the aged and disabled persons in a three-county area: Union, Spartanburg, and Cherokee counties. This demonstration began in July 1980 and is expected to end in July 1983. By that time, the project will be implemented on a statewide basis to all counties.

CLTC project was developed because few alternatives to nursing home placement existed to meet long-term care needs. The purpose of the project is to provide information for planning state policies. A service management system and new community services are being tested as ways of helping disabled persons to remain at home. Information will be gathered as a research basis to examine the impact of project services on clients and on the costs and utilization of institutional and community services.

The project is a response to an increasing growth in our elderly population, and to the incredible rising rates in health care costs. Between 1970 and 1978, the population of elderly in SC increased by more than 30 percent. Based on national estimates of disability rates, there were approximately 20,000 elderly disabled in SC. The nursing home industry is a major provider of institutional care due to governmental policies that promote institutional care. Medical costs for such care have increased rapidly: in SC costs have risen from $68.4 million in 1978 to $99.3 million in 1980. (p.1, CLTC project report, July 1980- May 1981)

The CLTC project was established by SC General Assembly in 1978. A Long-Term Care Policy Council was set up to direct the project. Members of the council include the Commissioners of the Departments of Social Services, Health and Environmental Control, Mental Retardation, Mental Health, the Director of Commission of Aging, and Governor or his representatives.

The initial project proposal was submitted to the Health Care Financing Administration (HCFA) of the Department of Health and Human Services in 1979. The project plan received conditional approval in November, 1979, and full approval in July, 1980. The project began in July, 1979 with a one-year preoperational period to prepare for the implementation of the demonstration. Among the activities of the preoperational year were revision of the project proposal, development of service contracts, staff recruitment, testing of the assessment instrument, and implementation of service management. The demonstration design was put into operation in July, 1980 and is scheduled to continue until July, 1983. The final evaluation is to be completed by March, 1984.

In order to be eligible for this project, participants must be 18 or over with some functional impairments resulting in long-term health care needs. This eligibility criteria included aged persons in nursing homes or the community who were unable to perform one or more daily activities (bathing, dressing, or eating) without help. They must also be eligible for Medicaid since all services available through CLTC are Medicaid funded. About 50 percent of older South Carolinians were eligible for Supplemental Security Income and all Medicaid benefits

(Budget and Control Board, 1979). Another 33 percent would have been eligible for Medicaid Assistance Only (MAO) benefits for care in a nursing home under Medicaid. Altogether, an estimated 16,600 disabled elderly were potentially eligible for Medicaid-sponsored nursing home care in 1978. (p.2, CLTC project report, July 1980 - May 1981)

The project report put forth by CLTC best summarize the purpose of the project:

> "The growing demand for long-term care services and the high costs of institutional care have prompted efforts to find more efficient and less costly ways of providing services. The need for a continuum of community and institutional services to meet the varying needs of the disabled has been recognized. Many of the elderly and disabled prefer to live at home whenever possible and for most, family members are the primary sources of support for ongoing personal care and household activities. Formal social supports from community agencies, hospitals, and nursing homes are typically accessed only after a medical or social crisis has occurred. A greater proportion of persons who enter nursing homes for long term care are widowed or childless and lack the social support networks needed to sustain themselves in the community." (p.2, CLTC project report, July 1980 - May 1981)

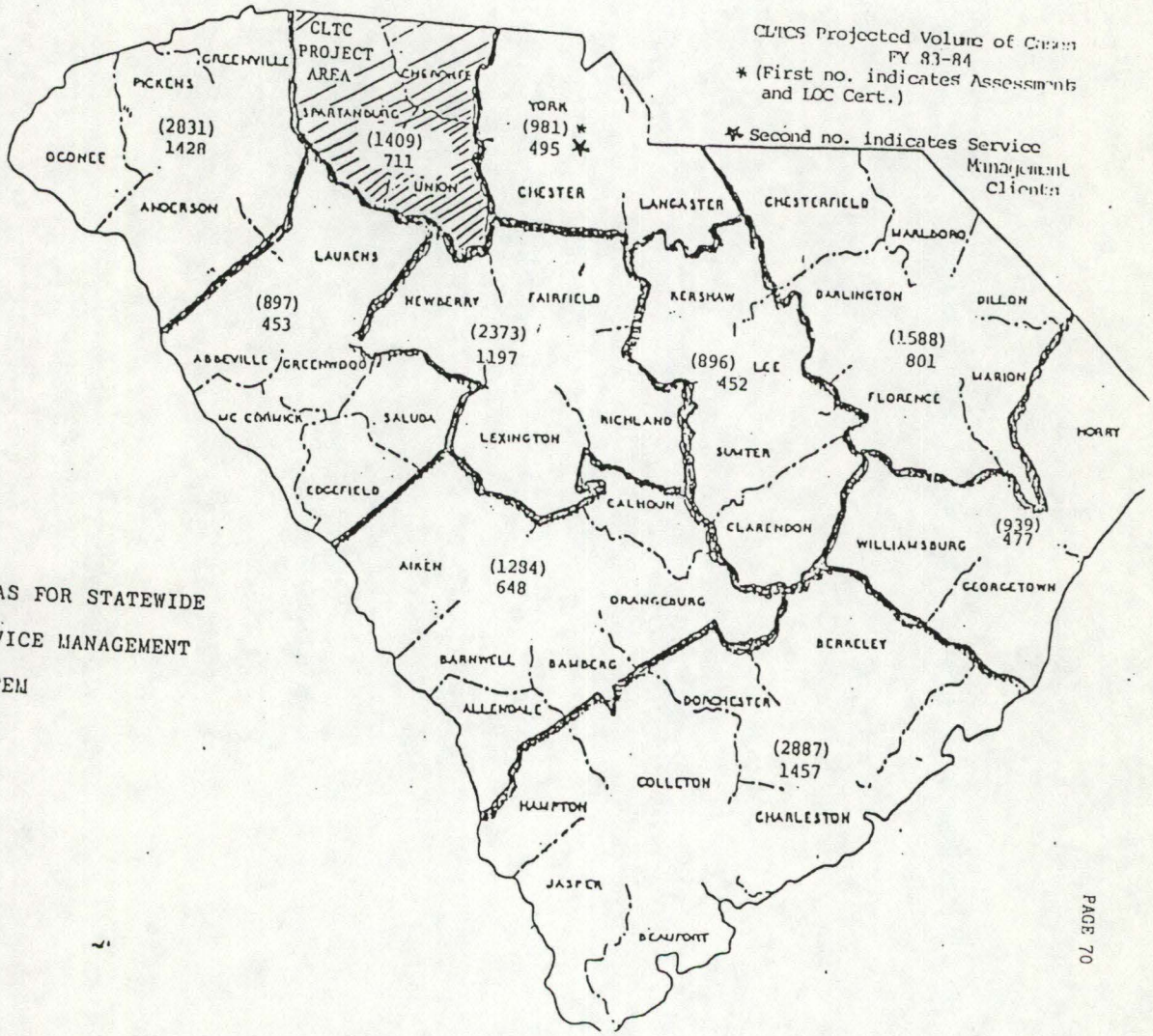
The following is a map which shows CLTC project area in South Carolina. In the Spartanburg area, there are 1409 cases of assessments, and 711 service management clients.

PROJECT OPERATIONS

The CLTC demonstration involves a longitudinal experimental design to examine the effects of project services over time. Related questions focus on the impact of the project on clients' health and wellbeing; on the utilization of community, hospital, and nursing home services; and on Medicaid and other public costs of client care. (p.4, CLTC project report, July 1980 - May 1981) A control group of clients who receive

TABLE 17

MAP OF SERVICE AREA



AREAS FOR STATEWIDE SERVICE MANAGEMENT SYSTEM

PAGE 70

standard services under present programs will be compared with an experimental group who are eligible for project services. Random assignment is used to insure that all clients have an equal probability of assignment to each group.

CLTC has listed seven functions it hopes to perform. They are:

1.) To assess the patient's/client's need for care.
2.) To certify level of care.
3.) To prepare a plan of care.
4.) To coordinate community resources to implement the plan of care.
5.) To reassess the patient's/client's circumstances on a periodic basis.
6.) To revise the plan of care when there are changes in the client's/patient's conditions or circumstances.
7.) To counsel with clients/patients and their families about long term care.
(SC DSS Information Memo I82)

Initial assessments are conducted by registered nurses and the project staff. Participants must sign a consent form prior to assessment. A comprehensive assessment instrument is used to evaluate current client status and characteristics in the areas of:

- mental status
- demographic characteristics
- medical and dietary status
- functional abilities
- social and familial supports
- home environment

The assessment process helps clients and their families to be aware of their needs as well as what is available in the community. Some may need to stay in nursing homes while others may only need community services. Assessment data also help to establish the basis for care planning, level of care certification, as well as providing a crucial research data base.

Following initial assessment, clients are randomly assigned to

either the experimental group, who may receive expanded community services, or the control group, who may receive standard services only. Each client has an equal chance of being assigned to either group. Clients assigned to the project's control group will have standard services paid for by Medicaid. Clients assigned to the experimental group may be provided expanded services not ordinarily paid for by Medicaid.

Concerning the experimental clients, waivers of Medicaid regulations were obtained so that reimbursement for these expanded services could be provided for these clients. Under CLTC policies, the cost of expanded community services is limited to a maximum of 75 percent of the cost of comparable institutional care, compiled over a 90-day period.

A waiver of eligibility requirements was obtained so that clients whose income is above the ceiling for SSI recipients can receive all Medicaid benefits. These clients were previously eligible for benefits only in nursing homes. A sliding scale of copayments is required from these clients to receive Medicaid benefits for expanded services as well as standard Medicaid services. (June 1981 CLTC project report)

The CLTC project recommends client either to nursing homes or to community services according to the patient's care needs, existing family support, and available services. The three levels of care are skilled nursing, intermediate care, and less than intermediate care. The last category means that a client does not meet the level of care requirements for nursing home admission; however, such clients are eligible to participate in the community long term care project. This

recommendation is made after consultation with the client and the client's family and physician.

Another very important function following initial assessment and recommending the proper levels of care to clients is the service management system.

SERVICE MANAGEMENT (CASE MANAGEMENT)

The CLTC case management process includes four steps to insure accurate placement of clients to services. They are periodic reassessment; service planning; service authorization, referral and termination; and utilization review. Although assessments and reassessments are performed for all project participants, only experimental clients receive all case management functions. Case management is carried out by social workers and registered nurses who are paired into service management teams.

The periodic reassessment process occurs at 90 days, 180 days, one year and once every six months thereafter. It is an abbreviated version of the initial assessment. The studies done on clients include demographic information, mental health status, level of morale, health status, and availability of social support. The deomgraphic information includes sex, race, age, education, occupation, income, sources of income, marital status, household composition and county of residence. Mental health status is assessed with a variety of items related to cognitive functioning and emotional wellbeing. Morale is evaluated by measuring levels of agitation, attitudes towards aging, and loneliness. Health data are collected on medical diagnosis, self-reported illnesses,

use of medical services and facilities, sensory capacities, personal habits, mobility and medications. The availability of supports for personal care include sources of support, availability of help, problem times, social contacts, and crisis events. Families are also involved in assessing problems and limitations regarding care.

A written plan is then made for each client's personal file. The plan states a client's problems and strengths, sets up goals and priorities for care, as well as stating existing services. Service plans are developed from assessment information and are updated as the client's circumstances change. The project staff will evaluate the effectiveness of such a plan as regards to serving the needs of the client and centralizing access to community services.

After a service plan is written, service managers prepare a written authorization for the client's use of expanded services provided under Medicaid waivers. The authorization is given only when the client is eligible for Medicaid and has the need for services. The authorization is based on the client's level of care and recommended location of care.

Periodic review is the last of the four steps in the case management system. It is a monitoring activity to insure that services are delivered appropriately and that services not needed would be terminated. This review serves as a useful purpose as it assesses the clients' as well as the services provided by CLTC project.

EXPANDED COMMUNITY SERVICES

In addition to service management activities that provide access to community services, the CLTC project offers experimental clients a

variety of new community services under Medicaid waivers. Services available through the project include medical day care; personal care; respite care; home delivered meals; medical social services; expanded therapies and mental health counseling. Another feature is that clients who are eligible for Medical Assistance Only (MAO) in nursing homes under current regulations may receive regular Medicaid services through the project. (p.8, July 10, 1981 report)

Medical day care is the first of such expanded community services. It is a program of health care and other services provided to promote, restore or maintain the health of clients. Services include nursing, social work, physical therapy, planned therapeutic activities, meals and personal hygiene. Transportation is provided to and from the center. The medical day care program for the experimental project is operated by Mountainview Nursing Home in Spartanburg. The cost of a day of service is $24.99 as of 1980. Occupational therapy is an additional service provided at the day care site for a rate of $15.00 per one-hour visit. Potential providers for medical day care include nursing homes, hospitals, and rehabilitation centers. These institutions have the resources available to provide the necessary range of professional and paraprofessional services.

Personal care services is another type of expanded services involved in helping with daily activities. Personal care aides, under the supervision of registered nurses, perform a variety of tasks necessary to help clients remain in their homes. Depending on the clients' needs, aides may help with bathing, dressing, toileting, meal preparation, housekeeping, shopping, laundry, medical monitoring or

other activities. The personal care service is provided under a contract with the Department of Health and Environmental Control. The cost for a two-hour unit of personal care is as of 1980 is $13.37. It is also likely that contracts for personal care could be developed with commercial or private, non-profit home health agencies.

Respite care involves temporary care for clients who live at home, with family members or others. The purpose of respite care is to permit primary care-givers to have some time from caregiving activities. Respite care may be based in an institution or in the client's home and the service may be used up to 14 days per year.

Regular or dietary meals are also provided and delivered to clients' homes. In Spartanburg County, CLTC clients receive their meals through Meals-On-Wheels program at no additional cost to Medicaid.

Home-based therapies are also available as an alternative to medical day care centers. They are trainned personnel providing physiotherapy, speech therapy, and occupational therapy services at home. Contracts for these services are being developed with a private home health agency.

Medical social services are also provided to help clients and their families to understand and adjust to the stresses of long-term illnesses. Medical social services are provided for project clients through a contract with the Department of Health and Environmental Control. Other potential providers would include hospitals and home health agencies.

Mental health services is the last but not the least important

expanded community service. Qualified professionals provide individual or group therapies under a care plan approved by a physician. These services may be provided to the client and his family in the client's home or at another setting.

It is previously mentioned that CLTC experimental clients who would ordinarily be eligible for Medicaid benefits only for institutional care can also receive regular Medicaid services. These benefits include Medicaid coverage for physicians, drugs and medical services. Experimental clients whose incomes fall in the MAO range from $238 to $714 must contribute a copayment based on income in order to receive a Medicaid card. Monthly copayments range from $9.60 to $28.60. Services are delivered through regular Medicaid providers within the existing system of hospital, pharmacy and medical services.

CLIENT SENSUS OF THE SPARTANBURG PROJECT

Between July 17, 1980 and June 30, 1981, a total of 1479 individuals were referred to the CLTC program (Figure 1). Initial assessments were done for 1187 persons. Of these individuals, 534 were assigned to the experimental group in which 373 of them became project participants; 572 went into the control group in which 387 became project participants; and 81 were unassigned.

Figure 1: Census Report, June 17, 1980 - June 30, 1981

Referrals	1479
Assessments Accomplished	1187
Experimental Assignments	534
Project Participants	373
Control Assignments	572
Project Participants	387
Not Assigned	81

The reasons why there was a difference between the number of referrals (1479) and the number of assessments accomplished (1187) are as follows: 51 persons died before an assessment could be done; 126 persons were screened out (under age 18, not residents of the project area, or no long term care needs); 5 who moved; and 78 who did not want to participate. There were 32 persons who had assessments pending as of June 30, 1981. As a result, 292 individuals were not assessed during the first year.

After the initial assessment there are still some dropouts in the project. As indicated in Figure 2, 534 persons were assigned to the experimental group and 161 did not become project participants. Of the 373 who became experimental clients, only 315 were participating as of June 30, 1981. The control group experienced greater attrition than the experimental group. Of the 572 assigned to the control group, 387 became clients and only 303 were participating as of June 30, 1981. The breakdown of the reasons for attrition of project clients are indicated in Figure 2. (P. 6-7, CLTC project report, June 11, 1982)

TABLE 18

ATTRITION OF PROJECT CLIENTS

Control Assignment	572	Experimental Assignment	534
Screened out	4	Screened out	4
Deaths	38	Deaths	39
Moved	5	Moved	10
Withdrew	8	Withdrew	14
Ineligible for Medicaid	130	Ineligible for Medicaid	90
Control Clients	387	Experimental Clients	373
Deaths	64	Deaths	46
Moved	15	Moved	9
Withdrew	2	Withdrew	0
Ineligible	3	Ineligible	3
Participating as of 6/30/81	303	Participating as of 6/30/81	315

Source: (p.7, Project Report, June 11, 1982)

CHARACTERISTICS OF PROJECT CLIENTS

When we discuss about the characteristics of project clients, we are concerned about the demographic characteristics, health status and social support of such clients.

CLTC clients represented a distinct segment of the area population. They are basically low-income aged and disabled persons, primarily women. The age distribution of persons assigned to both the experimental and control groups reflected the distinctive nature of the client population. The proportion of very old persons was large: 21 percent in the control group and 18 percent in the experimental group were age 85 and over, compared to 0.7 percent of the general population in the area. White females dominated both the control and experimental groups: 56 percent in the control group and 55 percent in the experimental group. This finding reflected differential mortality rates that favor the survival of white females over other combinations of race and sex. With regard to marital status, 56 percent in the control group and 50 percent in the experimental group were widowed; approximately 7 percent were divorced/separated for both groups; 28 percent were married in the control group and 33 percent in the experimental group; and about 10 percent were never married for both groups.

The experimental group was characterized by limited education and low incomes which is not surprising since they have to be eligible for Medicaid prior to eligbility for CLTC. Few persons had completed high school, and the principle occupations during working careers had been homemaker, skilled labor, farming, and unskilled labor. The limited educational and occupational opportunities were reflected in low levels

of retirement income. The major respondents had incomes between $200-$299 (about 46 percent for both groups). Approximately 19 percent of both groups had income level between $0-$199, and 18 percent of both groups had income level between $300-$399. The major sources of income were Social Security, Supplemental Security income, and Veteran's benefits.

TABLE 19

DEMOGRAPHIC CHARACTERISTICS BY GROUP

Level of Care	Control n=387	Experimental n=373
Skilled Care	17.8	12.9
Dual Intermediate Care	37.4	30.9
Free-Standing Intermed Care	32.5	31.5
Less Than Intermed Care	12.4	24.5
Age		
18-44	3.4	3.5
45-64	11.1	15.6
65-74	23.5	27.2
75-84	40.7	35.5
85 and over	21.4	18.3
Race and Sex		
White Male	22.8	23.5
White Female	56.1	54.9
Black Male	8.8	6.8
Black Female	12.4	14.9
Marital Status		
Married	27.5	33.4
Widowed	56.1	49.3
Divorced/Separated	6.8	6.7
Never Married	9.4	10.2
Monthly Income		
$0 - 199	18.7	20.2
200 - 299	46.6	45.2
300 - 399	17.9	18.0
400 - 499	5.4	5.3
500 and over	3.5	2.3
Not answered	7.9	9.0

Source: (p.8 CLTC project report, June 11, 1982.)

In view of the health status of project clients, a comparison between groups indicated that the experimental and control participants at each level of care entered the project with comparable degrees of impairment. Among the most common chronic disorders were circulation problems, heart conditions, arthritis, high blood pressure, respiratory problems, and renal conditions. At the time of initial assessment, 15 percent were too ill or confused to respond to any questions. An additional 14 percent did not pass a mental status questionnaire and were unable to complete the interview by themselves.

The functional abilities of clients to perform daily activities (ADL) were assessed. Between 35 to 50 percent of them reported difficulties in toileting, dressing, bathing, eating, and transferring themselves. Other items were related to instrumental functions (IADL), including medication, shopping, meal preparation, housework, and handling finances. The majority of clients were unable to perform IADL independently.

In terms of social support, the household composition of participants provided an indication of the availability of assistance from family members. A comparison shows that both the control and the experimental groups are similar in the proportions of family supports. The greatly impaired clients tend to live more with children, spouse or other relatives rather than living alone. The less impaired individuals when compared to the greatly impaired clients tend to live alone and with spouse rather than with children or other relatives.

The use of community services at initial assessment was compared for experimentals and controls at each level of care. The findings

indicated that more greatly impaired clients tend to use home health nursing services, whereas more less impaired clients tend to use homemaker and home delivered meals services. (See Table 2)

PROGRAM DEVELOPMENT

During the first operational year, the CLTC initiated service management and expanded community services for all experimental The volume of service management activities underwent a gradual increase throughout the year. Initially, referrals were received at an average rate of 135 per month, and an average of 103 initial assessments were completed each month. The volume of reassessments increased gradually over the course of the year. Active experimental cases increased at an average rate of 27 new cases per month.

Contracts for expanded services were negotiated throughout the first operational year. In July, 1980, a contract for personal care services was developed with the Appalachia III District of the Development of Health and Environmental Control. Personal care services include support for activities of daily living, housekeeping and medical monitoring of the client. During the first year, 21 percent of the experimental group utilized personal care services. These services were most heavily utilized by the nursing home level of care clients. The need for an increase in volume of personal care services had led to contracts with an additional provider, the Upjohn Company, in February 1982.

Medical day care was initiated in July 1980 under a contract with Mountainview Nursing Home. Medical day care services are designed

HOUSEHOLD COMPOSITION AND USE OF COMMUNITY SERVICES BY GROUP AND INITIAL LEVEL OF CARE

	SNF/DUAL ICF		FREE-STANDING ICF		LESS THAN ICF	
	CON.	EXP.	CON.	EXP.	CON.	EXP.
Household Comp.	N=214	N=164	N=125	N=118	N=48	N=91
Lived Alone	21%	19%	26%	27%	48%	40%
Lived with Spouse	29%	33%	19%	32%	31%	34%
Lived with Child	30%	23%	34%	23%	11%	9%
Lived with Other Relatives	16%	20%	14%	16%	7%	12%
Lived with Non-Relatives	5%	4%	8%	2%	4%	6%
Users of Community Services *						
Home Health Nursing	32%	38%	17%	31%	13%	16%
Home Health Aide	9%	12%	5%	5%	4%	1%
Homemaker	3%	3%	4%	6%	10%	6%
Home Delivered Meals	5%	7%	9%	12%	17%	13%

* Use of Community Services Prior to Initial Assessment by CLTC

Source: (p . 11, CLTC project report, June 11, 1982.)

for clients who need rehabilitative therapies. Patients were at the center for five to eight hours a day, for as many days as authorized by the CLTC service managers. The basic day of medical day care cost was $24.99, with additional charges for speech therapy, occupational therapy, and social work services. Medical day care services were used by about 4 percent of the group. The use of such services remained relatively stable, with approximately 10 individuals in service at any particular time.

A contract for therapeutic and regular home-delivered meals were negotiated with Cherokee County Services to the Aging, Inc., in November, 1980. This contract provided for the delivery of one or more meals per day up to five days per week, as authorized in the patient's care plan. The majority of meal recipients were served under existing meals programs, not under the Medicaid-sponsored meals contract.

Respite care was defined as a temporary placement in a nursing home facility of up to 14 days per year. This service was intended to provide primary caregivers with a period of relief from patient care. Contracts for respite care were implemented in October 1980 with Mountainview Nursing Home and November 1980 with Pinewood Convalescent Center. However, this service was underutilized during FY 1980-1981. The reasons for underutilization could be that few families wished to use nursing home-based respite care; that very few nursing home beds were available at the time; and that respite care was infrequently authorized by service managers as a needed service.

Other new Medicaid services included medical social services and expanded home health services: physiotherapy, occupational therapy, and

speech therapy.

Comparisons were made between the experimental and control groups based on Medicaid expenditures for eligible clients during FY 1980-81. Total Medicaid expenditures for specific categories of service were compared as were the costs per client day for each sub-group of the Medicaid-eligible clients.

The analysis actually represented a program-oriented study of expenditures, as opposed to a client-oriented study of costs over a period of each client's participation. Since the analysis covered only one project year, the subgroup of clients included persons who had different lengths of project participation. The analysis is to be interpreted as a study of program costs during the start-up period of the CLTC project, and not as an indication of the cost of serving specific types of clients for a year's time. (p.21, CLTC project report, June 11, 1982)

The following tables indicate that more control clients at nursing home levels of care (SNF/Dual ICF, FS-ICF) used nursing home care than comparable experimental clients. Consequently, the Medicaid costs for nursing home care were higher for the controls in the above category than for the experimentals in the same situation. The costs per user for regular Medicaid services were generally comparable between the groups.

Users and total costs for each of the waivered services were presented. Experimental clients at SNF/Dual ICF levels of care required more of the personal care and medical day care services than clients at

lower care levels. Few clients required Medicaid-sponsored meals or medical social work, as these services were often provided by non-Medicaid agencies.

Total Medicaid expenditures for control and experimental groups at each level of care were also presented. For each group of clients, the Medicaid cost per client per day was lower for the experimental clients. The cost difference was greatest for clients at the FS-ICF level of care. This finding suggested that the CLTC program may best serve Medicaid clients at a nursing home level of care who require less intensive care than the SNF/Dual ICF clients. However, costs of the program is very preliminary at this stage.

CONCLUSION

"The first operational year of the CLTC program achieved four major goals:

1.) Implementation of the project's experimental design,

2.) Implementation of service management for experimental clients,

3.) Development of new community services under Medicaid for experimental clients,

4.) Establishment of data bases for research."

(p. 27, CLTC project report: June 11, 1982)

The CLTC program demonstrated that a policy of mandatory pre-nursing home admission assessment and service management by experienced professionals were effective in helping disabled Medicaid clients obtain new as well as existing community services for in-home care.

Costs comparisons between experimental and control groups gave some indication that the CLTC program had an impact on nursing home use and Medicaid costs.

Results from comparisons of control and experimental clients who entered the CLTC program during FY 1980-81 showed that the groups were very similar on baseline characteristics, within each level of care. This finding suggests that those two groups could be compared on client outcomes, service utilizations, and costs over time to analyze the effectiveness of CLTC services.

The CLTC project team suggests a statewide implementation of mandatory pre-admission screening procedure and service management for nursing home clients who wish to remain at home. A more detailed study would be made on the comparisons of control and experimental groups, as well as the actual cost situation of the whole project. This will be possible only through time, experience, and accumulation of facts.

The following is a picture which shows how the whole system coordinates into a tight network, with services available from the community under different agencies coordinated by CLTC for the eligible client.

	SNF/DUAL ICF		IS-ICF		LESS THAN ICF	
	Control	Experimental	Control	Experimental	Control	Experimental
Number of Medicaid-eligible clients	170	164	104	118	19	91
Non-Medicaid eligible clients *	44	0	21	0	29	0
Total days of participation, Medicaid eligible clients	24,576	25,579	16,209	18,739	2,345	13,601
Nursing Home Use						
Number of users	87	56	49	25	2	3
Medicaid nursing home days	9,385	6,565	6,263	3,497	78	458
Medicaid costs	$297,704.00	$209,593.00	$184,956.00	$103,703.00	$3,265.00	$13,770.00
Dental Services						
Users	0	1	0	1	0	1
Medicaid costs	$ 0.00	$ 84.00	$ 0.00	$ 6.00	$ 0.00	$ 50.00
Drugs						
Users	119	115	74	88	9	71
Medicaid costs	$ 20,637.30	$ 17,959.60	$ 11,024.30	$ 11,245.40	$ 624.80	$ 7,682.60
Home Health						
Users	10	17	8	17	1	3
Medicaid costs	$ 7,991.70	$ 11,966.00	$ 3,362.10	$ 6,625.90	$ 356.50	$ 1,056.00
Inpatient Care						
Users	46	42	30	30	6	13
Medicaid costs	$ 4,533.30	$ 6,000.30	$ 2,557.10	$ 5,591.80	$ 364.40	$18,516.7
Outpatient Care						
Users	28	31	14	17	3	12
Medicaid costs	$ 559.07	$ 2,762.78	$ 194.53	$ 572.04	$ 38.40	$ 426.98

TABLE 21B

SRF/DUAL IV-F

	Control	Experimental	Control	Experimental	Control	Experimental
Physician Services						
Users	76	75	54	63	12	53
Medicaid costs	$ 5,345.43	$ 5,143.61	$ 3,316.30	$ 4,914.86	$ 147.85	$ 4,659.56
Supplemental Medical Insurance						
Users	55	52	41	44	10	21
Medicaid costs	$ 2,467.20	$ 1,651.20	$ 1,200.00	$ 1,785.60	$ 307.20	$ 1,161.60
Medical Equipment						
Users	8	21	7	5	0	5
Medicaid Costs	$ 824.95	$ 3,928.03	$ 351.84	$ 95.50	$ 0.00	$ 2,192.32
Other Medicaid Services						
Users	17	14	10	5	2	1
Medicaid costs	$ 352.49	$ 217.20	$ 242.52	$ 194.24	$ 155.00	$ 6.00
CLTC Waivered Services						
Medical Day Care						
Users	-	8	-	5		1
Medicaid Costs	-	$ 14,636.80	-	$ 4,764.70		$ 221.20
Personal Care						
Users		39	-	28	-	11
Medicaid Costs		$ 39,151.10	-	$ 18,400.00	-	$ 3,968.70
Home Delivered Meals						
Users	-	2	-	2	-	2
Medicaid Costs	-	$ 348.46	-	$ 631.42	-	$ 306.30
Medical Social Work						
Users	-	1	-	1	-	2
Medicaid Costs	-	$ 100.50	-	$ 321.72	-	$ 134.00
Assessment & Service Management						
Users	170	164	104	118	19	91
Medicaid Costs	$ 18,100.00	$ 31,735.64	$ 11,072.88	$ 22,834.18	$2,022.93	$17,609.41
Total Medicaid Costs	$356,048.00	$343,628.00	$217,077.00	$179,900.00	$6,975.00	$70,600.00

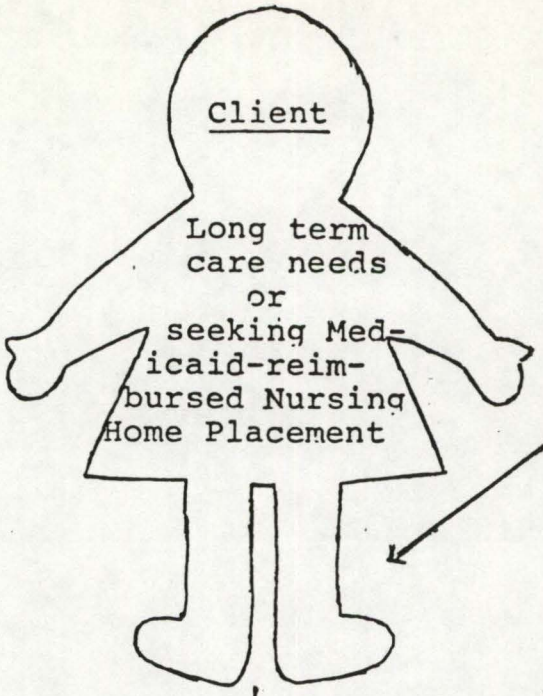
Costs comparisons between experimental and control groups gave some indication that the CLTC program had an impact on nursing home use and Medicaid costs.

Results from comparisons of control and experimental clients who entered the CLTC program during FY 1980-81 showed that the groups were very similar on baseline characteristics, within each level of care. This finding suggests that those two groups could be compared on client outcomes, service utilizations, and costs over time to analyze the effectiveness of CLTC services.

The CLTC project team suggests a statewide implementation of mandatory pre-admission screening procedure and service management for nursing home clients who wish to remain at home. A more detailed study would be made on the comparisons of control and experimental groups, as well as the actual cost situation of the whole project. This will be possible only through time, experience, and accumulation of facts.

The following is a picture which shows how the whole system coordinates into a tight network, with services available from the community under different agencies coordinated by CLTC for the eligible client.

Community Long Term Care System
Flow Chart
July 1982



Referral Sources
Clients and/or famili
Community agencies
(CoA,DHEC,DMH,DMR,DSS
Hospitals
Nursing Homes
Physicians

Assessment

Broker for services

CLTCS Area Office

:onsultation with client
ient's family
M.D.
unity agencies

Level of Care Certification

County DSS
Medicaid eligibil

clients 18 or older who are SNF or ICF level of care and are Medicaid-eligible

service plan
service management
N.H. authorization with Medicaid pay
Re-eval Level of Care prn

clients less ICF or non-Medicaid

for assessment, rdination, and delivery by:

Referral for service

CoA | DHEC | DMH | DMR | DSS

Agency Responsibilities

Provision of services to CLTCS clients reimbursed through regular programs of a particular agency
Assessment of clients and referral to CLTCS
Informing of clients of necessity to apply for Medicaid financial reimbursement

CHAPTER IV - CLTC REGIONAL PROVISION: GREENVILLE CLTC, SPECIFICALLY LOCAL ATTITUDES OF PICKENS COUNTY

INTRODUCTION

Greenville CLTC regional office, which is located on the ninth floor of Greenville General Hospital, is the headquarters of CLTC for the four-county area: Greenville, Anderson, Occonee, and Pickens counties. This headquarters office has been in operation since March 1, 1983, which is only about two weeks in lifespan before this chapter was written. The Area-Administrator of Greenville CLTC is from the Department of Social Services. She heads two teams composed of social workers and nurses who travel to and from all four counties. In July 1983, a satellite team will be set up in Anderson County.

As was mentioned in chapter III, the experimental project in Spartanburg has been in operation since 1979, Greenville CLTC is only one of ten statewide expansion regional projects conducted by the CLTC Council, located in Columbia. It was only put into operation after the Spartanburg project has proven to be economically feasible.

Greenville CLTC is part of the actual implementation of the statewide concept. The Spartanburg program, with its additional services, was only a demonstration project. Before we examine the situation of Greenville CLTC and its initial implementation phase, let us review and understand what the criteria for successful implementation of a program are.

CRITERIA FOR SUCCESSFUL IMPLEMENTATION

According to Ernest R. Alexander in "Implementation: Does A Literature Add Up To A Theory", there are four factors that can contribute to a successful implementation of any program. These four factors are effective communication, adequate resources, supportive disposition of implementers, and an appropriate bureaucratic structure.

In conjuction with the four factors for success, he also pointed out five reasons for policy failure: vague or unrealistic goals, lack of adequate support, poor implementation procedures, complexities of intergovernmental actions, and economic environmental forces.

Before we define any public program, we must first define what it means and what the goals and objectives are. Implementation is an open-ended process,as many forces both external and internal can critically affect the success of any program. In order to successfully carry out any project, we must be prepared to view it as a complex entity with all the complexity of joint actions. For example, apart from community support of the project, there are also political and economic difficulties that the federal government face in withholding program funds for local government agencies.

One answer to resolve confusion given by the author is to clearly and effectively partition your implementation process into three stages: policy formation, policy implementation, and policy evaluation. Policy formation would include clear definition of the program, realistic goals and objectives backed by thorough research, a careful plan for implementation, and a realization of limitations and shortcomings of the program. Policy implementation would be the actual carrying out of the goals and plans established in the policy formation stage, with the limitations and problems constantly in review for resolution. Finally, policy evaluation would evaluate and examine the differences and gaps between goals set up under the formation stage and the actual implementation stage. Such a critical analysis would be in the form of case study and serves as empirical evidence to back up your theories and goals

previously defined. In analyzing the success/ failure of a program, you can either disaggregate it into limited subsets or examine it as a whole. Since different program policies are not the same, it is better to disaggregate it into different subsets. Addressing everything as a whole can be overwhelming and may even leave out some critical factors in specific situations.

With all the criteria for a successful implementation in mind, we will now examine the Greenville CLTC's initial implementation phase, its goals and objectives, the complexities of joint governmental actions, and the economic and environmental factors that affect the program. Here, we are not attempting to evaluate whether the program is successful or not since it is very newly implemented. We are simply going to examine its formation and implementation processes. However, in order to give a clear overall picture, we have to also review the statewide CLTC in Columbia, South Carolina.

STATEWIDE CLTC: COLUMBIA, SOUTH CAROLINA

The Community Long Term Care Policy Council in Columbia, South Carolina finalized its policy to go statewide in 1982. Ten regional offices, including Greenville, would be established under the director of statewide CLTC. Each regional office is responsible for case management of eligible clients in its own area. The role of Columbia CLTC is to set up broad policies to ensure consistent application of such policies throughout the state.

There were several tasks that statewide CLTC implemented before regional offices were put into effect. The first step that they took was to

establish district boundaries to determine service areas for each regional office. Spartanburg CLTC in conjunction with Department of Social Services staffs developed the boundaries for ten districts based on a criterion of equal numbers of clients for each region. In addition, client travel distances within each region were also considered. The resulting boundaries which were finalized by mid-1982 do not reflect HSA or DHEC regions. However, all county boundaries were recognized. It is not an easy task to establish district boundaries in South Carolina because of an uneven distribution of population and cities.

Other tasks to be implemented were administrative procedures such as setting up offices, hiring and training staff, and initiating regional operation. Current service providers in each region were informed and trained for the coming of CLTC. CLTC staffs, on the other hand, had to establish direct links within the regions directly.

Meetings were held consistently by statewide CLTC to communicate and coordinate within each region. There were basically three types of sessions held. General sessions included statewide CLTC agency staff and all county level staffs from agencies who are service providers and are involved in CLTC. These agencies include Department of Social Services, Council on Aging, Department of Health and Environmental Control, Mental Health, and Mental Retardation. Representatives from statewide CLTC agency were present to answer questions and to increase credibility for the operation. The second type of meeting involved the county staffs of a for example Department of Social Services, but from different counties. specific department, The purpose of these meetings were to discover how each agency coordinates the program on a regional and statewide basis. The third type

of meeting involved all agencies from a single county, to discover how they can coordinate the program as a united entity within the county itself. Representatives from statewide CLTC were also present in both kinds of meetings.

The statewide budget cuts of FY 1983 have had definite effects on the statewide CLTC project. The biggest effect is that statewide implementation is delayed. So far, only large districts such as Orangeburg, Columbia, Greenville and Charleston have hired directors and set up regional offices.

After discussing the implementation of statewide CLTC in Columbia, we will now proceed to examine specifically Greenville CLTC.

GREENVILLE CLTC: GREENVILLE REGIONAL OFFICE

Initial Implementation Phase

The goal of Greenville CLTC is similar to that of the Spartanburg project and the whole statewide program. That is, to provide service management and assessment for aged and disabled persons who seek long term care services under Medicaid. By providing service management and access to community services, the program helps long term care patients to avoid unnecessary institutionalization.

Statewide expansion of CLTC was developed by the Long Term Care Policy Council and the staffs of the participating agencies: Department of Social Services, Department of Mental Health, Department of Health and Environmental Control, Director of the Commission on Aging, and the Director of the Division of Health and Human Services of the Governor's Office. The Community Long Term Care System will be gradually phased in

over a three year period. Pre-admission assessment of persons seeking Medicaid services in nursing homes began in January 1982. The implementation of the service management component began in the Spring of 1982, with a projected date of March 1983 for the service management activities.

From an interview with the Area-Administrator of Greenville CLTC there is evidence that service management activities were conducted true to the time schedule of March 1983. There are currently two teams of service managers under her supervision: a lead team consisting of a nurse and a social worker, and her own team consisting of a social worker, a nurse, a secretary and a clerk. The team approach to service management reflects the importance of skilled professional knowledge of the medical and social problems that face chronically ill and disabled persons and their families. In the initial phase of implementation, there is not much division of job contents. They all cooperate and communicate with the Spartanburg coordinators (since they were the pioneers in this state) and the headquarters at Columbia.

In the first two weeks of operation, Greenville CLTC received 95 applicants for referrals. These clients are considered eligible according to financial or categorical eligibility. They are Medicaid eligible persons aged 18 or over who have medical and social needs that would qualify them for nursing home care in the skilled nursing facilities (SNF) or intermediate care facilities (ICF).

In accordance with state policy and new Federal regulations that govern community long term care services under Medicaid, these 92 referrals have undergone a mandatory pre-admission assessment program in January 1982

when they sought Medicaid benefits for nursing home care. Assessments are completed by nurses and social workers who have received training in assessing the medical and social needs of disabled persons. The assessments are done by personnel in hospitals, nursing homes, and services agencies as part of the process of applying for Medicaid long term care services.

Preadmission assessments will be sent to the local area offices. In the beginning stages of Greenville CLTC, however, service management teams have to visit clients in all four counties because there are as yet no local offices being set up. They will examine the clients' level of care certifications. For all persons who are at SNF or ICF level of care, the service managers will prepare a plan of care that identifies the clients' medical and social needs, strengths and weaknesses in the clients' current supports, and community services that could be used to help the clients remain in their homes. This will permit clients who are Medicaid-eligible to choose between community-based long term care and nursing home care. Clients who choose to remain in their homes will receive ongoing service management by the nurses and social workers of the CLTC staff.

Services provided in the community vary from county to county. Most of the services provided in Greenville are similar to the ones listed in chapter I - they are basic services such as homemaker, transportation, dining, socialization and recreation, referral, escort, and life-line services. These services are provided by the community as well as by state agencies such as the Department of Social Services and Council on Aging. Unlike the Spartanburg project, Greenville CLTC does not have Medicaid/ Medicare waivers, they have to make the best use of existing services in the community. After examining the goals, structure, types of services, and

preadmission assessment plans of the program, we will now see how they implement their service plan.

Implementation of the Service Plan

Service managers are responsible for contacting the providers of services and seeing that the needed services are initiated. This process will involve ongoing communication with the client, his family, and service agency personnel to make sure that the appropriate services are delivered, and to coordinate services when several agencies are involved. Service managers must monitor the delivery of services and initiate changes in services as the client's needs changes.

Apart from contacting community services providers and counseling clients and their families, service managers must also periodically reassess clients to recertify the client's level of care in accordance with Medicaid regulations. Information from reassessments will be used to revise care plans to meet the changes in the client's needs.

Service management functions will be carried out as long as the client remains Medicaid-eligible for long term care benefits and chooses to stay at home. Service management will also be initiated for residents of nursing homes who seek to be discharged to the community for long term care.

Additional services that are demonstrated to be effective as community resources for long term care may be added to the Medicaid program in the future.

Critical Factors for Successful Implementation

We have mentioned previously that in order for a project to be successful, there must be effective communication, adequate resources, supportive disposition of implementors, and an appropriate bureaucratic structure. In an interview with the Area-Administrator of Greenville CLTC,

she mentioned certain critical factors that can contribute to the success of the program. Those critical factors include community support, adequate services and resources, constructive utilization of such services and resources, and noncompetitiveness from other public agencies. All of these critical factors fit in with Alexanders' five reasons for policy failure: lack of adequate support, poor implementation procedures, complexities of intergovernmental actions, and economic environmental forces.

The first critical factor - community support - is closely related to economic environmental forces and competition from other agencies. One of the major difficulties that a new program faces in times of budget cuts is competition and jealousy from other agencies. Other agencies may feel that more money should be allocated to them to expand their existing services rather than to support a totally new program. Especially not a program that may seem to have an overseeing or service management power, guiding clients to community agencies and making sure that such agencies provide the best and most suitable services to clients. Moreover, CLTC is more extensive than other agencies in that it does followup and continues to provide case management to clients as long as they are in the program.

The second critical factor - that of adequate resources and services is very hard to control since funding comes from federal and state levels and their funds are severely limited. Greenville CLTC will have to do the best they can with existing services and a minimum staff that can continue effectively to carry out the program.

Doing the best with what they have, in other words, is to utilize existing services and resources constructively . Good evidence of poor utilization of existing resources is the shortage of nursing home beds that

is a result of bias in nursing home choice of clients. In the end, the most unsuitable clients are placed in nursing homes thus creating a shortage of beds for those who are in real need for them.

Another constructive way to utilize existing services, according to the Area-Administrator, is to effectively coordinate them under a case management approach. Community services such as homemaker services, personal care, transportation, day-care, boarding homes, and even nursing homes can jointly cooperate to meet the needs of our elderly population. Nursing homes have so far been quite resentful of the Community Long Term Care program. After CLTC came into legal existence, nursing homes have to certify medical necessity for all their patients in a utilization review. This increases their paper work load due to changes in levels of care in their own facilities. It also removes some of their discretion and selectivity in the admission process.

CONCLUSION

Due to the newness of Greenville CLTC, it is impossible to study the impact or effectiveness of the program on the region. We have examined its initial implementation, defined its goals and objectives; established certain factors that can determine the success or failure of the program; described the organizational structure - its team approach, its relationship with all four counties, and reviewed some of its implementation plan - preadmission assessment, case management, counseling, and continuing reassessment.

Evaluation of the program can not be conducted until at least one year of operation is completed. In the meanwhile, research from Spartanburg project will continue to guide regional operation. In fact, Greenville CLTC is working closely with Spartanburg CLTC. In my opinion, Greenville CLTC is quite organized in their initial implementation phase. They are aware of all the political, economic, and community factors that can critically affect their program. They are also very clear about their goals and objectives, and that is the first criterion for a successful implementation of any plan.

CLTC AT PICKENS COUNTY

Pickens County as yet does not have a CLTC county office, and it is not anticipated to have one in the near future. According to the Department of Social Services, Greenville CLTC is only 20 miles away from Pickens County. The proximity together with the small population size of Pickens County make it unnecessary for a county office to exist at this point.

Existing Services for the Aged

The Department of Social Services at Pickens County provides protective services which are social, medical and legal in nature to those individuals who, because of a physical or mental handicap or advanced age, are not able to deal with everyday living.

The purpose of protective services is three-fold:

1.) To see that an adult is protected from abuse, neglect or exploitation by himself or another;
2.) To see that an adult's own resources, as well as the resources provided by the community, are effectively used to assure him of proper care;
3.) To protect the community when an adult behaves in ways that may endanger himself or others.

There is currently a homemaker service provided by the Department of Social Services to coordinate voluntary help for those who are aged and/or disabled. There are also transportation services for various activities such as social, recreational and medical. This is conducted on a voluntary basis, plus a van provided by Medicaid from Greenville which transports them for medical appointments. The Department of Social Services is now advocating a RCTA, 'Residential Care for Two Adults' program. This program is to provide foster family care for aged and disabled persons aged 18 or older who cannot live alone. Licensing requirements would include a private

room when possible, adequate bathroom facilities, nutritious meals, and recreational opportunities. To participate, a home must meet these minimum licensing requirements.

Meals-On-Wheels is a private-donation program which provides a balanced meal five days a week for shut-ins persons. The two locations in Pickens County that have Meals-On-Wheels programs are Cannon Memorial Hospital and Six Miles Retirement Center. Such a service not only provides adequate nutrition, but also socialization and a checking opportunity in case anything happens to the individuals.

The Council on Aging has a nurse who acts as a long term care coordinator (ombusmen) for families, nursing homes, and clients. There is a calling system which makes sure that all participants are being checked daily so that anything that goes wrong is detected early. There is a transportation system which carries the elderly within and outside close proximity of the county anywhere they wish to go. Congregate meals are also provided five days a week by the Council on Aging. This provides an adequate meal as well as socialization opportunities.

The Health Department also has several programs related to the elderly. Immunizations and checking of blood pressures are common services. Home health services provides skilled nursing care, speech therapy, physical therapy, medical social work, nutrition education and counseling, home health aide and homemaker services to those who are homebound and under the care of a doctor. The program is available to anyone who is in medical need of the service and who meets the above requirements.

Medical ambulatory care is also provided by the Health Department. This is an innovative day care/health care project done in collaboration with a private day care facility. The project provides transportation, meals, intensive health teaching, socialization and nursing care to patients who visit the day care facility for about 6 to 8 hours a day, on weekends, for a period of about 3 to 4 weeks. The program serves Greenville and Pickens County residents who have a medical condition which is under the care of a doctor and which can be improved by participation on the program. The program is designed to provide patients with the skills and knowledge that are necessary to be more independent and to play a more active role in their treatment plan on their return home.

Implementation of CLTC in Pickens County

Due to a bed shortage in nursing homes, the implementation of CLTC in Pickens County is expected to operate favorably. According to the Department of Social Services, there has only been one case that they dealt directly with Greenville CLTC so far. When a client comes through any public services departments seeking for aid, the pre-admission form will be sent to Greenville for certification. The Greenville office will send a case worker to visit the client and consult with physician on the appropriate level of care for the client. If there is any chance that the client can remain at home, the case worker will coordinate a range of services from meals delivery, medical assistance at home, to socialization and help with bathing, etc. that will be brought to the client at home. The final choice, of course, will rest with the client himself as to whether he wants to stay at home or not.

Local Attitudes Towards CLTC

The Department of Social Services sees this implementation process as being quite optimistic and favorable. They feel that by letting CLTC coordinate it takes off some work load from the department. CLTC will also be more able to concentrate on the coordination than the Department of Social Services would. The follow-up reassessment plan is considered extremely important. If a change in level of care is detected early enough, there may be a shortening of hospital nursing home stay and thereby reducing bed shortage. The Department of Social Services also feel that Greenville CLTC is a lot closer than Columbia - previously each case would have to be reported to Columbia, but now it can be handled in Greenville.

Council on Aging, however, feels that CLTC may not be necessary. They feel that the county is adequately providing services to the community and there was no need for a third party operating from Greenville to barge into the system. CoA so far has dealt with CLTC on two cases. In both cases, they feel that CLTC had recommended a lower level of care than the clients' actual needs. They question the validity of CLTC's assessment accuracy and they also question the justification of another full staff in times of budget constraints when some of CoA staffs were only paid on a part-time basis.

The opposing points of view create an interesting atmosphere. Some of the questions that need to be addressed include the following: how would opposing community agencies affect the effective implementation of CLTC which depends so much on the coordination of all existing services available in the community? Is the political tension purely an economic issue, or is it jealousy among agencies for more funds and attention? Would

CLTC pose any real threats to some agencies in the community? Would it benefit also only some agencies and not others? There is no doubt that the system will continue to expand in its casework. How then would CLTC in the future deal with such opposition? How can they make full use of other supportive agencies such as Department of Social Services? Are they aware of the political tension now in the early stage and try to solve it?

Such questions are beyond the scope of this paper to answer. However, it is essential to be aware of outside forces that can affect the success of the implementation process. As health care professionals we have the responsibility not only to satisfy clients but to be able to create in the community a harmonious atmosphere for everyone to work as a whole unit. Unity and coordination are the essence of this project to achieve two major goals: enable clients to remain at home, thereby lowering the rising costs of institutional care.

CHAPTER V - CONCLUSION

Community Long Term Care System is designed to be a viable means of providing an alternative to institutional care for the aged and disabled persons in South Carolina. The experimental project in Spartanburg County has achieved the following four goals:

1.) Implementation of the project's experimental design;
2.) Implementation of service management for experimental clients;
3.) Development of new community services under Medicaid for experimental clients;
4.) Establishment of data bases for research.

The project demonstrated that a policy of mandatory pre-nursing home admission assessment and service management by experienced professionals effective in helping disabled Medicaid clients obtain new as well as existing community services for in-home care.

Statewide implementation of the CLTC concept basically follow the seven functions listed below:

1.) To assess the patients'/clients' need for care;
2.) To certify level of care;
3.) To prepare a plan of care;
4.) To coordinate community resources to implement the plan of care;
5.) To reassess the patients'/clients' circumstances on a periodic basis;
6.) To revise the plan of care when there are changes in the clients' /patients' conditions or circumstances;
7.) To counsel with clients/patients and their families about long term care.

Greenville CLTC is a focus of this study. In its implementation phase it is working to achieve the four factors needed for successful implementation of a program: effective communication with health care professionals and clients and their families; adequate resources from assessment procedures and full utilization of existing community services; ana ppropriate bureaucratic structure in which there is support from Columbia and enough autonomy to coordinate local services. We must realize, however, that CLTC is a hybrid of state departments. The nature

of implementing a demonstration project on a statewide basis means dealing with existing systems, power centers, and established customs and ways. In addition, CLTC is only one of ten regional offices, there is less special treatment as can be shown by the lack of experimental services.

Currently there is disagreement in the local CoA with the operation of CLTC. This factor should not be ignored but should be studied early enough to avoid any problematic dissensions in the future. In implementing any program one should be aware of the political and economic environmental forces and the complexities of intergovernmental actions that can act against the well being of the organization. As long as CLTC is aware of the feelings and attitudes of local agencies, it can act in a way that resolves conflict and can then lead to effective implementation. CLTC is still in its early stages of statewide implementation. The regional staff in Greenville is aware of its functions, supporters, and opponents. It is still too early to insure successful implementation, as state agencies support, state and federal funding and policies, and political alliances are all not entirely fixed or favorable.

APPENDIX

APPENDIX I - AREA AGENCIES ON AGING

In 1965, Congress passed the Older Americans Act, which heralded an alternative approach to providing social services for the elderly. The Act provides services to people whose income and assets rendered them ineligible for services from other public welfare agencies. It also adheres to the principle that the elderly have special needs and, in regard to services, should be considered separately from the general public. It was a comprehensive legislation for it responded to a broad range of needs.

> "The original act of 1965 and its subsequent amendments committed the federal government to assisting older people in obtaining an adequate retirement income, the best possible physical and mental health care, suitable housing, and opportunities for individual initiative in planning and managing their own lives." (p. 239, Berghorn, Schafer and Associates, 1981)

In order to implement all these provisions, the Older Americans Act established an organizational and funding structure for providing services. As part of the 1973 amendments to the act, the Area Agencies on Aging were created. They were established as private, nonprofit organizations, with each agency serving a specific geographical area. There is an average of ten area agencies per state, and they receive funds for implementing their services from their respective state agencies on aging. The state departments on aging, in turn, receive an appropriation from the Administration on Aging, which is under the Department of Health, Education and Welfare. Each area agency has the responsibility of identifying the needs of older people. The agency must subcontract funds to community organizations that can provide the appropriate services for responding to the needs of older people. In addition, it is mandated to oversee the development of specific support services, such as information and referral and legal services. By assisting in the coordination of programs, the

agency can help improve the existing service network. It can also locate additional community resources with which to inaugurate new programs. (Berghorn, Schafer and Associates, 1981)

In essence, then, the Administration on Aging and the Area Agencies on Aging, along with their subcontracted organizations, represent the major formal network supporting the elderly population of the United States. The design of the network is to have input from older citizens. Therefore each local agency creates an advisory council consisting of representatives from the elderly population as well as the general public. Since conditions affecting the needs of elderly people will vary from one locality to another, it is appropriate that priorities for meeting such needs be established by the local agencies.

In a survey of the nation's Area Agencies on Aging done by Berghorn, Schafer and Associates, 1981, it was found that the highest priority needs identified at the local level were transportation, income assistance, information and referral, nutrition services, health services and treatment, and homemaker services.

The AAAs have been quite successful in bringing more older people to participate in programs, and in bringing more programs to the people. However, it is far from reaching all old people in need or responding to the full range of needs and wants of older people effectively. "Concern is often expressed among AAA staff about identifying and making available services to the 'hidden aged' - i.e., persons whose lifestyles and life experiences make them unlikely to readily seek out help from formal service systems even if it is badly needed." (pp. 250, Berghorn, Schafer and Associates, 1981)

Some explanations to limited success include first of all, a dependency upon the AoA since the major funding source for most AAAs continues to be the AoA. This dependency has obstructed the AAAs from expending full effort to create linkages with other existing service networks. Secondly, the states were at different stages of development in their ability to deliver services to older people when the AAAs were created. States having a history of established programs for the aging had a definite advantage over states lacking such a history. It has also been noted that urban AAAs have experienced somewhat less difficulty in establishing ongoing comprehensive programs than their rural counterparts. In part, at least, this reflects the richer and more concentrated resource base typically present in urban as opposed to rural settings. The AAAs have also experienced difficulty in establishing credibility with local communities and counties within their planning and service areas and in attracting and holding highly skilled staff to conduct program activities. The future planning of the AAAs is to try as best to overcome the above limitations within their limited budget.

APPENDIX II - A REFERENCE TO GOVERNMENT AND FOUNDATION FUNDING SOURCES IN THE FIELD OF AGING

The federal government has in the past two decades, dramatically increased its role in the area of grant awards. The elderly, as the fastest growing segment of the American popoulation, have been the target of many recent federal programs, such as the Older American Act of 1965. Byron D. Gold, special assistant to the United States Commission on Aging, described two roles the government presently takes in providing funding to programs on aging (Cohen, Reich, 1977). The first role is to support research on both the causes and manifestations of human aging. The activities of the newly created National Institute of Aging, one of the National Institutes of Health is an example. The second role involves meeting the costs of providing a variety of social services to subsets of the older population. To achieve this, the federal government provides financial support to public and private organizations at the state and local levels. An example is the meals-on-wheel program under the Older Americans Act, which provides meals to ambulatory older persons in group settings and to shut-ins in their homes.

Federal grants to states and localities have doubled in the four years between 1969 and 1973. There are basically three funding mechanisms provided by the federal government to address the needs of target segments of our society. These are categorical grants, block grants, and general revenue sharing.

The categorical grant programs were the earliest mechanisms used for the distribution of federal funds. They are created mainly to address to a specific need or problem, and applications are usually approved on a

competitive basis. Applicants for categorical grants are usually state or local governments, nonprofit organizations and individuals.

The second type of funding mechanism is block grants. Block grants are usually provided according to some formula such as population, unemployment figures, or other socioeconomic factors. Such grants allow the agency great flexibility in the use of funds as long as they are applied to the overall purpose for which they are appropriated.

Block grant programs often require state and local financial participation in the programs. An example of a block grant legislation is the Comprehensive Employment and Training Act (CETA) in the area of manpower training and employment.

The third type of federal funding is a relatively recent development known as general revenue sharing. The program was legislated in 1972 to return federal funds directly to local or state governments to solve local problems. The program utilizes a formula based on population, relative income, general tax effort, urbanized population, and state income tax. Revenue sharing funds are usually given for any purpose and with very little restrictions. They can also be allocated to public and private nonprofit organizations in the community. However, experience has shown that groups interested in receiving revenue sharing funds should have strong working relationships with local governing bodies such as the city manager's office or the city council. (Cohen, Reich, 1977)

States often play an important role as intermediaries between local governments and the federal government. One example of this is the State Area Agencies on Aging, which administer programs under the Older Americans

Act. State governments, however, in assessing needs, may determine that there are gaps in services and will provide their own funds to initiate new programs for the aging. (Cohen, Reich, 1977)

Funding Under The Older Americans Act

The 1961 White House Conference on Aging, initiated a legislation to establish a "permanent and effective focal and advocacy point for the aging within the federal government." (pp. 7 Cohen, Reich, 1977) It was the first time that a proposal was made that would be based on the interests of a particular client group, covering all areas of concern to that group. Title II of this act established the Department of Human Development, which was to be a subdivision of the Department of Health, Education and Welfare.

One major program under the Older Amercians Act is Title III, which created a comprehensive and coordinated structure at the state level. The state has the freedom, responsibility and independence to analyze situations and set up priorities. The 1973 amendment to this act extended this concept of leadership to the local level, and the result was the establishment of area agencies on aging. Such agencies were asked to mobilize all their resources and create comprehensive and coordinated programs that would perform the following major functions: "provide leadership, determine needs, inventory resources, establish 'measurable' program objectives, plan with existing planning agencies, and through contract or grant (1) coordinate delivery of existing services and (2) pool untapped resources of public and private agencies." (pp. 7, Cohen, Reich, 1977)

Title III area agencies rarely provide direct services, and therefore will subcontract with local agencies for such services. Thus, this provides

another source of funds for private and nonprofit agencies. State agencies try their best to fund area agencies when they provide programs that would assist older persons to become aware of the services available in the area (such as information and referral, and outreach services). They will also fund these agencies when they assist the elderly in having access to those services (such as transportation and escort services). Finally, area agencies are encouraged to provide services needed by older persons, but which no public and private agencies of the area can or will provide. Overall, the basic theory is to aid the older persons to maintain themselves in a home environment.

The major purposes that the Older Americans Act hope to achieve are to provide information about services which are available to seniors and to provide the means of gaining access to them. Beyond these would be such aims as coordinating the service system and pooling untapped resources, in the hope that there will be a continuation of programs even if federal support at times is withdrawn.

Special Programs for the Aging

13.633 Aging Programs - Title III State Agency Activities and Area Planning and Social Service programs

FEDERAL AGENCY: Office of Human Development, Department of Health, Education, and Welfare

OBJECTIVES: To provide assistance to State and Area organizations for support of programs for older persons via statewide planning, area planning and social services.

TYPES OF ASSISTANCE: Formula Grants

USES AND USE RESTRICTIONS: Funds are awarded to states to develop or strengthen comprehensive coordinated service systems through a network of designated State agencies on Aging and area agencies on Aging. Annual State Plans must be submitted for approval to the Commissioner on Aging, and Area plans to the State agencies for approval. Use of funds is dictated by the content of approved plans except that all funds must be used solely for the benefit of older persons.

ELIGIBILITY REQUIREMENTS:

Applicant Eligibility: All states and territorities with approved State Plans and State agencies on Aging designated by the governors.
Beneficiary Eligibility: Older persons, especially low income and minority older persons.

APPLICATION PROCEDURE: State Plans are required to be submitted by the State Governor or a prescribed State Plan format.

RANGE and AVERAGE of FINANCIAL ASSISTANCE: SAPSS - $205,000 to $7,004,327, $1,464,286. SSA - $62,500 to $1,191,453; $289,910.

13.224 HEALTH SERVICES DEVELOPMENT - PROJECT GRANTS
(Public Health Service Act, Section 330)

FEDERAL AGENCY: Health Services Administration, Public Health Service, Department of Health, Education, and Welfare.

OBJECTIVES: To support the development and operation of community health centers which provide primary health services, supplemental health services and environmental health services to medically underserved populations. In 1976, priorities will be focused on the maintenance of existing centers, monitor and assess project performance, develop and implement mechanisms for improving quality of care, and maximizing third party reimbursement levels, through improved project administration and management.

TYPES OF ASSISTANCE: Project Grants.

USES AND USE RESTRICTIONS: Services must be provided in accordance with plans of the State comprehensive health planning agency. Proposals designed to improve the accessibility and organization of health care within medically underserved communities, through community health centers, will receive highest priority. Funds may be used for acquiring and modernizing existing buildings, including the costs of amortizing the principal and paying the interest on loans.

ELIGIBILITY REQUIREMENTS:

Applicant Eligibility: State and local governments, any public or nonprofit private agency, institution, or organization. Profit making organizations are not eligible.
Beneficiary Eligibility: Population groups in medically underserved areas.

RANGE and AVERAGE of FINANCIAL ASSISTANCE: $25,000 to $4,000,000; $1,203,731.

13.771 SOCIAL SERVICES FOR LOW INCOME AND PUBLIC ASSISTANCE RECIPIENTS

FEDERAL AGENCY: Social and Rehablitation service, Department of Health, Education, and Welfare.

OBJECTIVES: To enable states to provide social services to public assistance recipients and other low income persons directed toward one of the five goals specified in the law.

TYPES OF ASSISTANCE: Formula Grants

USES AND USE RESTRICTIONS: Federal funds may be used for the proper and efficient operation of social services programs to enable eligible individuals to become or remain self supporting and self sufficient; to prevent neglect, abuse or exploitation of children and adults; to prevent inappropriate institutional care; and to arrange for institutional care, when appropriate. Federal funds cannot be used for public education services that are generally available, land acquisition or services provided by institutions to their inmates. There are other restrictions with respect to medical care, room and board, day care services, inkind matching, donated funds, and cash payments as a service. Fees must be charged for services provided to specified income eligible persons.

ELIGIBILITY REQUIREMENTS:

Applicant Eligibility: Designated Title XX State agencies in the fifty states and the District of Columbia.
Beneficiary Eligibility: Any recipient of Aid to Families with Dependent Children, Supplementary Security Income payment recipients or State supplementary payment recipients as well as low income individuals. Individuals whose gross monthly income exceeds 115 percent of the median income are not eligible for services.

RANGE and AVERAGE of FINANCIAL ASSISTANCE: $3,169,000 to $245,500,000; $47,000,000.

Supportive and Protective Services - Title XX, Social Security Act

Title XX of the Social Services Act is administered under the Social and Rehabilitation Service (SRS) of the Department of Health, Education, and Welfare. It should be viewed by advocates for the elderly, or elderly individuals themselves, as potential sources of services.

Programs directly benefitting the elderly that have been provided under Title XX include senior centers, homemakers, protective services, transportation and escort services, and legal services.

Title XX anticipates considerable citizen input concerning needed services and methods of delivery. However, timing is essential; it is important to seek involvement in Title XX programming at the earliest possible time if the needs of the elderly are to be given adequate consideration. Senior groups should be aware of how Title XX planning works and how their involvement can enhance Title XX services for older persons.

In addition, there is research to discover, test, demonstrate and utilize new social concepts which will provide service to selected target areas of population, such as the poor, aged, children and youths.

APPENDIX III - INCOME POLICIES AND PROGRAMS

The income policies and programs that concern us in this context include: social security program, supplemental security income, private and public pensions, other sources of income such as employment and food stamps, and tax benefits.

Social Security Program

The part of the Social Security Program that benefits the elderly population is popularly known as Old Age, Survivors and Disability Insurance Program (OASDI). This program is administered entirely by the federal government through the Social Security Administration (SSA) and its approximately 1,300 branch offices.

Whether one is eligible for social security retirement benefits depends on earnings and not on needs. An elder person aged 62 can receive reduced benefits and at age 65, he can receive full benefits. His/her family and wife/husband can also receive benefits under auxilliary benefits.

The amount of the monthly social security check is based on the past earnings of the retiree. There is, however, a ceiling on the amount of earnings creditable to social security so that beyond a certain point, a worker's earnings cannot increase the social security benefits. The ceiling for 1980 was $122,200. (pp. 54, Lowy, 1980)

The maximum monthly benefit payable to a retired worker generally would be over $400. The minimum retirement benefit for a worker retiring at 65 will be frozen at the minimum level in effect in January 1979 (about $121).

As of 1972, there is a provision for an automatic benefit escalator whenever the cost of living increases by 3 percent or more. However, Congress has not taken action to increase benefits.

The entire amount of social security benefits goes to the retirees; social security benefits presently are not subject to federal income tax.

Within the Social Security Act, there is also a survivor's insurance program and a disability insurance program. The survivor's-insurance component of social security provides cash benefits to family members of an insured worker who dies.

The disability insurance component assists those workers under age 65 who are unable to perform any substantial gainful work. When a disabled beneficiary reaches age 65 the payments are converted to retirement benefits.

As defined by the Social Security Act, disability means "an inability to work caused by: (1) any severe physical or mental impairment that has lasted or is expected to last at least twelve months or to result in death; (2) or blindness." (pp. 56, Lowy, 1980) Such benefits would terminate once the disability ceases. However, there will still be a two-month payment as trial period to see if he will recover fully on his job.

Supplementary Security Income

In 1974, Supplementary Security Income (SSI) replaced the major welfare program for the aged, blind, and disabled, "Old Age Assistance" (OAA) program under Title XVI of the Social Security Act. The SSI was supposed to achieve the following goals: "provide poor people with more

cash to spend; a national minimum income for the aged, blind, and disabled; uniform eligibility conditions instead of conditions that differed widely from state to state under OAA." (pp. 58, Lowy, 1980)

The difference between SSI and OASDI was that SSI was based on needs while OASDI was based on earnings.

There are two types of benefits under SSI: the basic federal payment and optional state supplementary payments. However, states are obligated to assist the federal government in their payments.

In order to be eligible for SSI, a person must meet four basic requirements:

> "(1) one must be either aged 65 or over, blind, or disabled; (2) one must have an income below a certain specified amount (as of 1977, the income levels were $177.80 monthly for an individual, and $266.70 for a couple); (3) one must possess resources - total property other than income - less than a certain amount; (4) one must meet certain general qualifications such as U.S. residency and U.S. citizenship (or resident-alien status)." (pp. 59, Lowy, 1980)

Private Pensions

A pension can be defined as "any fund, plan or program that provides retirement income to employees or results in a deferral of income to employees until the termination of employment or beyond." (pp. 67, Lowy, 1980)

There are two basic types of pension plans. In the defined or fixed-benefit plan, an employee receives a fixed amount of benefits on retirement in terms of dollar amount or on a percentage basis. In the defined - contributions or purchase - money plan, the employee will have a fixed amount each year that will have a fixed amount each year that will be

allocated to him based on his age, length of employment, and rate of pay. On retirement, a pension annuity will be purchased from insurance companies with the money invested in the account of the retiring employee.

A third type of pension plan is a profit-sharing plan. In a profit-sharing plan, the company lets employees participate in a share of the employer's profits; they are considered to be pension plans under the Employee Retirement Income Security Act of 1974 (ERISA), the law that now governs the creation and adminstration of private pension plans.

Private pension plans have the following problems: it is difficult to make private pensions inflation-proof; and it is also difficult to make private pensions portable - that is, to allow workers to have job mobility without a reduction in the value of their pension rights relative to what the value would be if they did not change jobs. (pp. 74, Lowy, 1980)

Public Pensions

Federal, state and local employee pension-plan programs are rapidly growing sources of retirement income for older people. Two federal laws governing such programs are the Civil Service Retirement Law and the Railroad Retirement Act. Unlike private pensions, there is no single law that provides guidelines for the creation and maintenance of public retirement systems. (pp. 74, Lowy, 1980)

Other Sources of Income

Employment, noncash incomes such as food stamps, and tax benefits are other major sources for older people to meet some of their financial and economic needs, although they do not provide for income security on a universal basis.

(1) Employment

In 1977, about 2.9 million or 13 percent of older people were in the labor force - either working or actively seeking work; they make up 3 percent of the U.S. labor force. (See Table)

It would be a good idea to have a national coordinated plan to eliminate existing elderly-employment barriers. This can lift a burden off the taxpayers' pockets, and the elderly will also benefit from work in a psychological, social, and financial perspective.

In 1978, Congress enacted amendments to the Age Discrimination in Employment Act (ADEA) that prohibit mandatory retirement before age 70, and protect most federal employees completely against age-based retirement.

(2) Food Stamps

The Food Stamp Act of 1964 was established to provide adequate levels of nutrition for all Americans. Run by the Department of Agriculture, the Food Stamp Administration uses national standards based on family size and income level to process applications and certify eligibility.

Food stamps are given to two kinds of households: public assistance households and nonpublic-assistance households. A household is a group of people whether related or not, that meets three requirements. The group must live together as an economic unit, they must share common cooking facilities, and they must usually buy food together. (pp.78, Lowy, 1980)

Public assistance households are those that have residents on welfare, they are automatically eligible for food stamps. A nonpublic-assistance household is one in which either some or none members are on welfare. Nonpublic-assistance households are eligible for food stamps if they meet

certain income and resources tests.

(3) Tax Benefits

Other types of tax benefits include exemptions of prescription drugs from sales tax and certain income-tax breaks - special income levels for filing returns; higher personal exemptions; special medical deductions; special treatment of retirement income; and tax credits. (pp.79, Lowy, 1980)

APPENDIX IV - HEALTH POLICIES AND PROGRAMS

The programs we are concerned about here are Medicare, Medicaid, and long-term care.

Medicare is a health-insurance program for the elderly sponsored by the federal government through the Social Security Administration, under Title XVIII of the Social Security Act. There are two parts to the Medicare program: Part A deals with hospital insurance, which pays for hospital, skilled-nursing facility and some home-health services; part B deals with supplementary medical insurance, which covers physician services, hospital outpatient services, and other forms of medical treatment.

The majority of medicare recipients are also receiving social security old-age benefits. Part A of Medicare, similar to social security, is funded by taxes on earnings of those currently employed or selfemployed. Part B is paid in part by the monthly premiums of those insured and partly by federal contributions from general revenues.

The actual payment for such services, however, is handled by private insurance companies under contract to the federal government. State agencies have the responsibility of inspecting providers of such services - hospitals, nursing homes, and home-health agencies - to make sure that they meet the conditions of participation in the Medicare program.

There are certain services that Medicare does not cover: services and supplies that are "not reasonable and necessary for the diagnosis and treatment of illness or injury." (pp. 94, Lowy, 1980) Such services would include custodial care less than daily skilled-nursing services; services paid for by a government agency such as care in a Veterans Administration

facility; routine physical examinations; prescriptions and nonprescription drugs and medicines; eyeglasses and examinations to fit glasses; dentures and routine dental treatment; immunizations and cosmetic surgery.

Most of these services not included in Medicare funding are easily identifiable and specific. Some services such as custodial care are more vague and can give rise to court litigations.

Medicaid

Medicaid was established in 1965 under the Social Security Act Title XIX. It is a cooperative federal-state medical-assistance program for the needy poor. Medicaid is more of a welfare program than an insurance program such as Medicare. It is also based on proven need in terms of eligibility. Like Medicare, it pays for a broad range of medical services.

Medicaid is funded jointly by the federal government and state governments. There are federal guidelines for the program, but the responsibility for its administration lies with state agencies. As with Medicare, payment of Medicaid claims in many states is handled by private insurance organizations.

In order to be eligible for Medicaid, a person must be either over 65 years of age, blind, or disabled receiving supplementary security income (SSI) . He can receive benefits if he belongs to the categorical needy (based on income levels), or the medical needy (based on medical expenses).

Benefits available under Medicaid vary from state to state. There are, however, certain basic mandatory services that are provided: inpatient hospital services; outpatient hospital services; physician services; X-ray and laboratory services; and skilled-nursing-home services. Medicaid must

also pay for a recipient's transportation if it is necessary to secure medical care.

In addition to the above mandatory services, there are also a variety of optional benefits available such as dental care, prescription drugs, mental hospital care, home-health care and private-nursing services, and so forth.

The Medicaid recipient has full freedom of choice to select the physician as provider of medical services. In many states, a recipient must obtain prior authorization from state agencies before he can accept any services. In rural areas, nonavailability of physicians is a major problem for medicare and medicaid recipients.

Long Term Care (Nursing Homes)

This section deals with federal payments to nursing homes under Medicare and Medicaid.

Medicare will pay for up to one hundred days of care in a "single spell of illness", which begins with hospital admission and ends sixty days after the last medicare-covered treatment.

Medicaid eligibility varies from state to state. It also varies on the amount of coverage for nursing-home care. However, states are required by federal regulations to provide SNF care to Medicaid-eligible recipients, they may also choose to provide ICF care and to extend the coverage to medically needed Medicaid recipients. Unlike Medicare, most states place no duration limits on Medicaid-reimbursed care.

To be eligible for Medicare or Medicaid benefits, a recipient must

have "a physician certification stating that the care is medically necessary; and a utilization review committee functioning within the nursing home to periodically review the patient's continuing need for the level of care provided by the facility." (pp. 106, Lowy, 1980) This mechanism serves as a means of cost control, and it also ensures that nursing homes provide the right level of care for their recipients.

GLOSSARY

AREA AGENCIES ON AGING (AAAs)

Area Agencies On Aging was created in 1973 as part of an amendment to the Older Americans Act. AAAs were established as private, nonprofit organizations, with each agency serving the needs of a specific geographical area.

ACTIVITIY OF DAILY LIVING (ADL)

Activity of Daily Living is a set of indicators to determine the degree of independence an older person has to handle tasks such as shopping, cooking, and cleaning.

AOA

Administration On Aging

BLOCK GRANT

A federal funding mechanism which usually provides funds according to some formula such as population, unemployment figures, or other socioeconomic factors.

CATEGORICAL GRANT

A federal funding mechanism to address to a specific need or needs of target segments of the society. Applications are usually approved on a competitive basis.

COMMUNITY LONG TERM CARE SYSTEM (CLTCS)

Community Long Term Care System was established throughout the state of South Carolina to coordinate existing services in the community for the elderly population.

COA

Council On Aging

DHEC

Department of Health and Environmental Control

DHEW

Department of Health, Education and Welfare

DHHS

Department of Health and Human Services

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (HUD)

HUD provides funds to construct housing or to subsidize rents for the elderly and for low and middle income families.

DSS

Department of Social Services

FOSTER CARE HOME (FCH)

Foster Care Home is private home that provides services to an elderly person.

GENERAL REVENUE SHARING

A federal funding mechanism that returns federal funds directly to local or state governments to solve local problems. The program utilizes a formula based on population, relative income, general tax effort, urbanized population, and state income tax.

HCFA

Health Care Financing Administration, part of the Department of Health and Human Services.

HIS

Health Interview Survey

HSA

Health Systems Agency

INTERMEDIATE CARE FACILITIES (ICFS)

ICFs are less intensive care intended for patients who require care only on an intermediate basis.

MEALS-ON-WHEELS

Meals-On-Wheels is a private-donation program which provides a balanced meal five days a week for shut-ins persons.

MEDICAID

Medicaid was established in 1965 under the Social Security Act Title XIX. It is a cooperative federal-state medical-assistance program for the elderly poor.

MEDICAID ASSISTANCE ONLY (MAO)

Medicaid Assistance Only, an eligibility-related benefits for care in a nursing home under Medicaid.

MEDICARE

Medicare is a health-insurance program for the elderly sponsored by the federal government through the Social Security Administration, under Title XVIII of the Social Security Act.

NATIONAL NURSING HOME SURVEY (NNHS)

NNHS is a survey on residents in nursing homes.

OLD AGE, SURVIVORS AND DISABILITY INSURANCE PROGRAM (OASDI)

OASDI is part of the Social Security program that benefits the elderly population. It is administered entirely by the federal government through the Social Security Administration (SSA).

OLDER AMERICAN ACT

The Older American Act was passed by Congress in 1965 to provide services to people whose income and assets rendered them ineligible for services from other public welfare agencies. It recognizes the special needs of the older people.

RESIDENTIAL CARE FOR TWO ADULTS (RCTA)

RCTA was advocated by the Department of Social Services. This program provides foster family care for the aged and disabled persons aged 18 or older who cannot live alone.

SKILLED NURSING FACILITIES (SNFS)

SNFs provide 24-hour skilled nursing care under the supervision of a physician.

SUPPLEMENTARY SECURITY INCOME (SSI)

SSI replaced the major welfare program for the aged, blind, and disabled, "Old Age Assistance" (OAA) program under Title XVI of the Social Security Act in 1979.

SURVEY OF INSTITUTIONALIZED PERSONS (SIP)

SIP conducted by the Census Bureau in 1976, provides data on the utilization of nursing homes and other long-term care institutions.

TITLE III - OLDER AMERICANS ACT

Title III of the Older Americans Act is a comprehensive and coordinated structure at the state and local level. The state has the freedom, responsibility and independence to analyze situations and set up priorities. The result is the establishment of Area Agencies On Aging.

TITLE XX OF SOCIAL SERVICES ACT

Title XX is administered under the Social and Rehabilitation Service of the Department of Health, Education, and Welfare (DHEW). It should be viewed as a potential source of services for the elderly population.

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